SEPTEMBER 1961
Volume 51, Number 9

JOURNAL OF THE AMERICAN PODIATRY ASSOCIATION

The Official Publication of the Podiatry-Chiropody Profession

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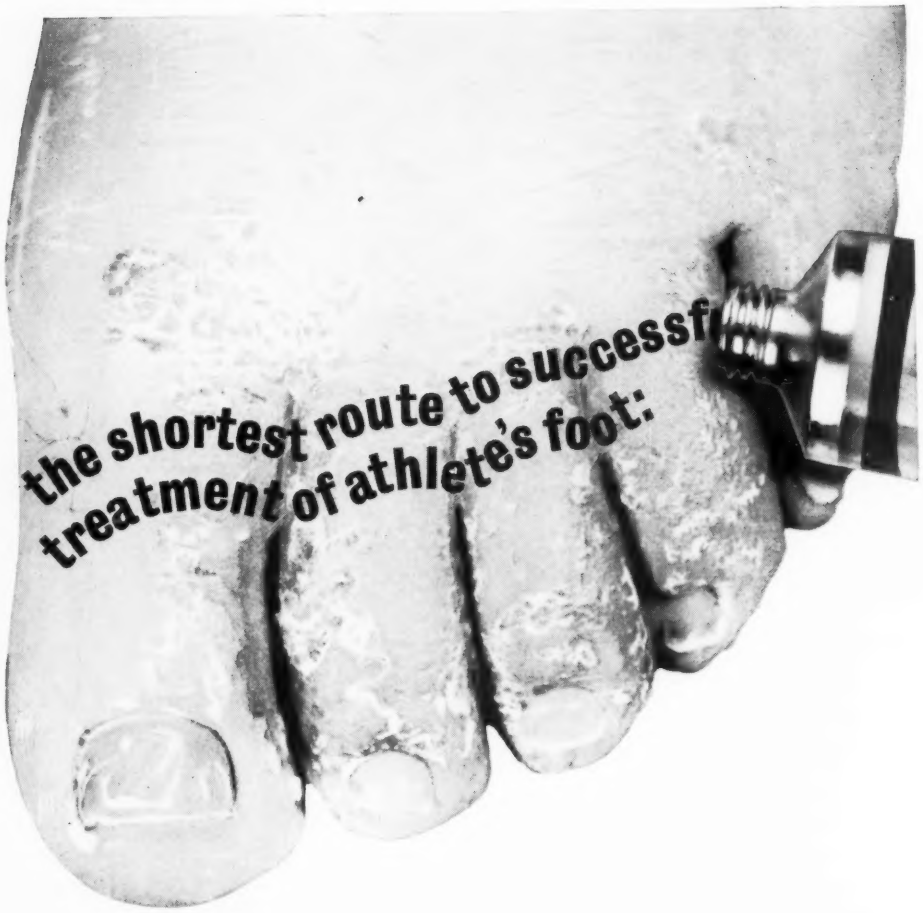

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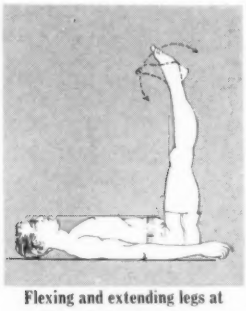
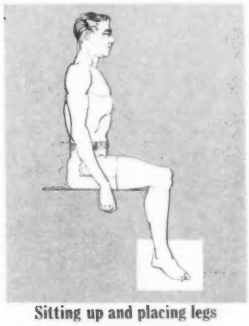
The patient lies flat with his legs elevated to a 90° angle while he flexes and extends his feet repeatedly for one minute. If arterial flow is impaired, the distal portion of the elevated limb exhibits pallor, which may be delayed somewhat when arterial disease is mild. With marked circulatory impairment, pallor may not appear at all since reactive hyperemia may be present before elevation. When the patient sits up and places his legs in a dependent position, reactive hyperemia normally produces a bright red color fairly promptly. A delay of 45 to 60 seconds indicates some degree of arterial impairment.



Flexing and extending legs at 90° angle for one minute.



Sitting up and placing legs in dependent position.

When varicosities are present, this test is not reliable, since skin color may return very promptly in dependency whether arterial circulation is impaired or not.[2] Rapid development of cyanosis in dependency indicates low or absent superficial vessel tone. In continued dependency, intense cyanotic rubor develops slowly when local circulation is impaired.

Awareness of this phenomenon and routine use of this test will undoubtedly further earlier diagnosis, permit institution of therapy sooner, and improve the likelihood of a favorable response to therapy.

(1) Winsor, T.: Peripheral Vascular Diseases, Springfield, Illinois, Charles C Thomas, 1959, pp. 457-458. (2) Abramson, D. I.: S. Clin. North America *40*:3-14 (Feb.) 1960.

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References: (1) Samuels, S. S., and Shaftel, H. E.: J.A.M.A. *171*:142-145 (Sept. 12) 1959. (2) Kaindl, F.; Samuels, S. S.; Selman, D., and Shaftel, H.: Angiology *10*:185-192 (Aug.) 1959. (3) Clarkson, I. S., and Le Pere, D. M.: Angiology *11*:190-192 (June) 1960.

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Indexed in Index Medicus, formerly Current List of Medical Literature, National Library of Medicine.

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The Journal of the American Podiatry Association is published monthly and copyrighted in 1961 by the American Podiatry Association.

Entered as second class matter at the P. O. at Boston, Mass., March 27, 1934, under the act of March 3, 1879, re-entered March 3, 1958. Publication office, 375 Broadway, Boston, and Editorial Executive offices, 3301 16th St., N.W., Washington 10, D. C.

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1. Sokoloff, O.: A.M.A. Arch. Dermat. and Syph. *64*:754, 1951. 2. Van De Erve, J.: A.M.A. Arch. Dermat. and Syph. *68*:572, 1953. 3. Bleiberg, J.: personal communication. 4. Tobey, J.: personal communication.

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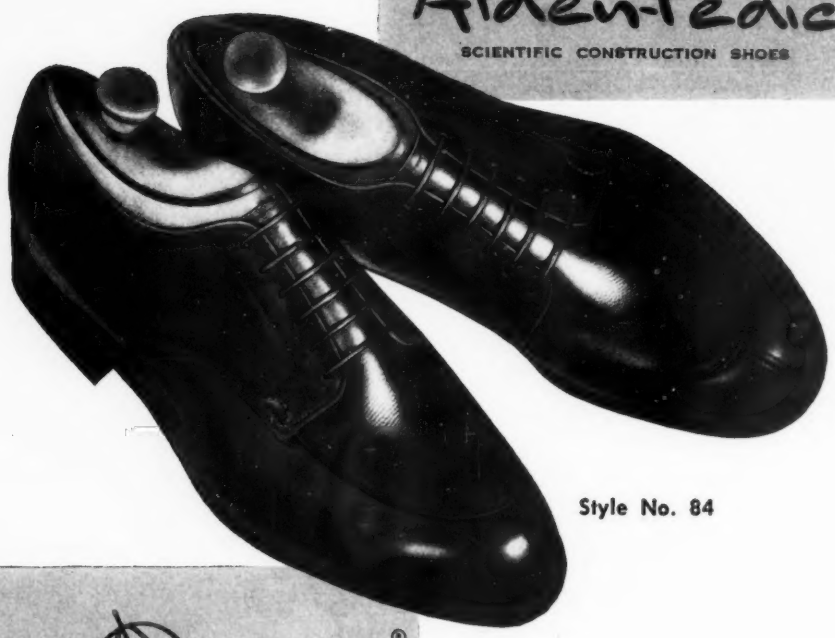

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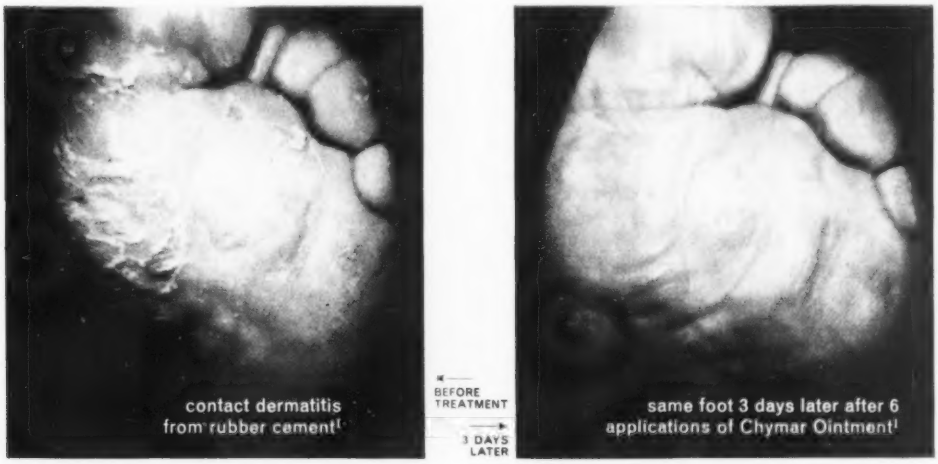
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1. Walker, M. H.: The Therapeutic Use of a Corticosteroid-Antibiotic-Enzyme Ointment in Common Foot Lesions, to be published. 2. Lucas, R. D.: Current Podiatry (March) 1960. 3. Streiker, F. B.: The Use of Chymotrypsin in Foot Orthopedics. Paper Presented at the Annual Meeting, American Podiatry Association, Chicago, Illinois, August, 1960.

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Oklahoma Chiropody Association	Earl Weibel, 1921 N.W. 23rd St., Oklahoma City, Okla. Lafe C. Midkiff, 3101 Classen Blvd., Oklahoma City, Okla.
Oregon Podiatry Association, Inc.	George McCauley, 4126 N. E. Broadway, Portland, Ore. William V. Wheeler, 405 High St., N. E., Salem, Ore.
Pennsylvania, Podiatry Society of	Joseph D. Fletcher, 520 Temple Bldg., New Castle, Pa. Arnold W. Newman, 5411 Chester Ave., Philadelphia, Pa. George W. Thomas (Ex. Sec.), 227 State St., Harrisburg, Pa.
Rhode Island Podiatry Society	Edward L. Hochman, 452 Main St., Pawtucket, R. I. Leonard H. Lerner, 1045 Warwick Ave., Warwick, R. I.
South Carolina Podiatry Association	James D. Hill, 122 W. Whitner St., Anderson, S. C. H. A. McAninch, 169 Hall St., Spartanburg, S. C.
South Dakota Association of Chiropodists	Fred D. Rule, 204 Kresge Bldg., Sioux Falls, S. Dak. E. A. Laga, 303 Medical Arts Bldg., Watertown, S. Dak.
Tennessee Chiropody Association	Donald R. Skwor, 1306 Exchange Bldg., Memphis, Tenn. Ronald E. Fields, 524 Bennie Dillon Bldg., Nashville, Tenn.
Texas, Chiropody Society of	Buford M. Sanders, 1000 Hospital Dr., Tyler, Tex. J. Gordon Russell, Goodhue Bldg., Beaumont, Tex. C. J. M. Roesch (Ex. Sec.), 407 Austin Savings Bldg., Austin, Tex.
Utah Podiatry Association	Lorin L. Richards, 837 East 21 South, Salt Lake City, Utah Blaine C. Grose, 5168 S. State St., Murray 7, Utah
Vermont Chiropody Association	Gray S. Clark, 128 Merchants Row, Rutland, Vt. Regis P. Nolin, 14 Clarke St., Burlington, Vt.
Virginia, Podiatry Society of	Herman Chapel, New Monroe Bldg., Norfolk, Va. I. Leonard Kaplan, 718 Court St., Portsmouth, Va.
Washington State Podiatry Association	Heber H. Routh, 511 Fidelity Bldg., Spokane, Wash. Robert H. Armstrong, 409 General Insurance Bldg., Seattle 5, Wash.
West Virginia, Podiatry Society of	W. C. Baber, 204 Union Bank Bldg., Clarksburg, W. Va. G. A. Taylor, 1st Huntington Natl. Bank Bldg., Huntington, W. Va
Wisconsin Society of Chiropodists	Eugene V. Hurtienne, 2705 North 8th St., Sheboygan, Wis. Michel M. Addis, Med. Arts Bldg., 945 N. 12 St., Milwaukee 3, Wis.
Wyoming Podiatry Society	E. O. King, 615 S. Durbin St., Casper 12, Wyo. Duane NeuSchultz, 2201 West A, Torrington, Wyo.

AFFILIATED ORGANIZATIONS

Women's Auxiliary A.P.A. (N.A.C.)—Mrs. Helene Broun, 4916 No. Central Park, Chicago 25, Ill.
Military Association of Podiatrists—Lt. John L. Charlton, Jr., D.S.C., Podiatry Clinic, Walter Reed Army Hospital, Washington, D. C.
American College of Foot Surgeons—J. M. Kohl, 3959 No. Lincoln Ave., Chicago 13, Ill.
American Society of Chiropodical Roentgenology—Joseph L. Starr, 1115 Main St., Bridgeport, Conn.
Chiropody Bibliographical Research Society—S. E. Reed, 425 Kresge Bldg., Des Moines, Iowa.
American College of Foot Orthopedists—Murray Bromberg, 56 Broad St., Bloomfield, N. J.
American Association of Hospital Podiatrists—Louis J. Arancia, 7725 Fourth Ave., Brooklyn 9, N. Y.
American Podiatry Students Association—Bruce Wood, 296 Eureka St., San Francisco, Calif.
American Board of Chiropodical Dermatology—Joy E. Adams, Florida National Bank Bldg., St. Petersburg, Fla.

RELATED

Federation of Chiropody-Podiatry Boards—L. A. Hansen, 800 Professional Bldg., Kansas City, Mo.
American Association of Colleges of Chiropody—Charles E. Krausz, 926 W. Lehigh Ave., Philadelphia, Pa.
National Board of Chiropody Examiners—Pierce B. Nelson, 1770 Eddy St., San Francisco, Cal.
American Academy of Chiropodists—Robert Smith, 77 James St. North, Hamilton, Ontario 10, Canada.
Academy of Podiatry—Louis Lewy, 285 Madison Ave., New York, N. Y.
American Podiatry Council—L. J. Friedman, 1186 Broadway, New York, N. Y.
Fellows Pedic Research Society—Irving M. Sward, 4948 W. Dempster Rd., Skokie, Ill.
American Foot Health Foundation—Sidney Hirschberg, 107-07 Continental Ave., Forest Hills, N. Y.

Accredited Colleges

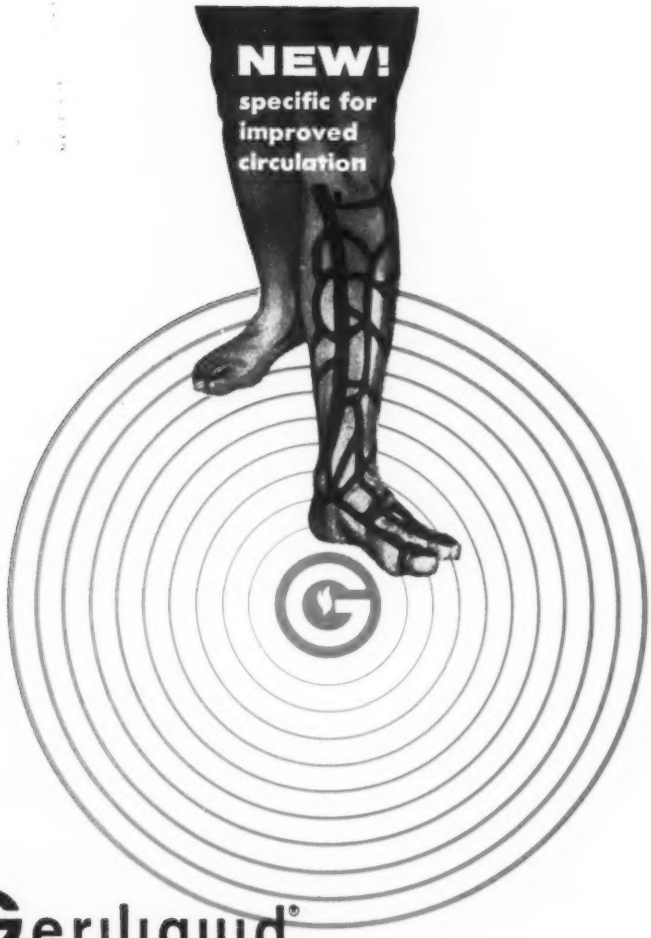
California Podiatry College
1770 Eddy Street, San Francisco, Calif.

M. J. Lewi College of Podiatry
53 East 12th Street, New York, N. Y.

Chicago College of Chiropody
1422 W. Monroe Street, Chicago, Ill.

Ohio College of Chiropody
2057 Cornell Road, Cleveland, Ohio

Illinois College of Chiropody & Foot Surgery
1327 North Clark Street, Chicago, Ill.



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FOR EXAMINATION AND LICENSURE

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The Alabama Medical Board of Examiners. **Board Secretary:** Edward E. Sealy, 39 S. Perry St., Montgomery, Ala.

Arizona

Arizona State Board of Chiropody Examiners. **Board Secretary:** Martin Snyder, D.S.C., 2629 E. Broadway, Tucson, Ariz.

Arkansas

Arkansas State Chiropody Examining Board. **Board Secretary:** Dr. Bernard S. Paul, 1508 Rogers Ave., Fort Smith, Ark.

California

The California Chiropody Examination Committee will meet for examination tentatively Oct. 17-18, 1961 in Sacramento. **Board Chairman:** Abraham Hoffman, D.S.C., 2320 Sutter St., San Francisco, Calif. **Executive Secretary:** Mr. Wallace Thompson, 1021 O St., Sacramento 15, Calif.

Colorado

Colorado State Board of Chiropody Examiners. **Board President:** Dr. G. F. Helbig, 327 Logan St., Denver, Colo.

Connecticut

The Connecticut Board of Examiners in Chiropody. **Board Secretary:** Dr. F. J. Ruggiero, 3 South Main Street, W. Hartford 7, Conn.

Delaware

The State Board of Chiropody Examiners of Delaware. **Board Secretary:** Dr. Bertram H. Blum, 112 So. State St., Dover, Dela.

District of Columbia

The Board of Podiatry Examiners of the District of Columbia. **Board Secretary:** Harry L. Hoffman, Ph.G., D.S.C., Dept. of Occupations and Professions, 1710 Massachusetts Ave., N.W., Washington 6, D. C.

Florida

The Florida State Board of Chiropody Examiners. **Board Secretary:** Dr. Heywood A. Dowling, 203 Greenleaf Bldg., Jacksonville, Fla.

Georgia

The Georgia State Board of Podiatry Examiners. **Board President:** Dr. Charles W. Beasley, Jr., 1205 First National Bank Bldg., Atlanta, Ga.

Hawaii

The Hawaii Podiatry Board. **Board Secretary:** Dr. R. K. Lee, P.O. Box 3378, Honolulu, Hawaii.

Idaho

The Idaho State Board of Chiropody-Podiatry. **Board Secretary:** Dr. J. E. Franden, 412 Eastman Bldg., Boise, Idaho.

Illinois

The Illinois Chiropody Examining Committee. **Superintendent of Registration:** Fredric B. Selke, Room 112, State House, Springfield, Ill.

Indiana

The Indiana State Board of Podiatry Examiners. **Board Secretary:** P. T. Lamey, M.D., 422 Citizens Bank Bldg., Anderson, Ind.

Iowa

The Iowa State Board of Chiropody Examiners. **Board Secretary:** Dr. C. C. Reinheimer, 111 W. 2nd St. South, Newton, Iowa.

Kansas

The Kansas State Board of Podiatry Examiners. **Board President:** Dr. L. E. Krause, 1107 Williams St., Great Bend, Kansas, or Kansas Board of Podiatry Examiners, 872 New Brotherhood Bldg., Kansas City, Kansas. **Board Secretary:** F. N. Nash, M.D., 364 New Brotherhood Bldg., Kansas City, Kansas.

Kentucky

The Kentucky State Board of Chiropody meets on the third Saturday and Sunday of June and the first Saturday and Sunday of December each year. The December meeting is for re-examination only. **Board Secretary:** Dr. Chester A. Nava, 4140 Shelbyville Rd., Louisville 7, Ky.

Louisiana

Louisiana State Board of Medical Examiners. **Board Secretary:** Edwin Lawson, M.D., 930 Hibernia Bank Bldg., New Orleans 12, La.

Maine

The Maine Board of Examiners in Chiropody and Podiatry. **Board Secretary:** Daniel A. Hanley, M.D., Box 637, Brunswick, Me.

Maryland

The Maryland Board of Chiropody Examiners. **Board Secretary:** Dr. S. Jack Kleger, 408 S. Division St., Salisbury, Md.

Massachusetts

The Massachusetts Board of Registration in Chiropody-Podiatry. **Board Secretary:** Dr. Charles H. Thorner, 910 Furnace Brook Parkway, Quincy, Mass.

Michigan

The Michigan State Board of Registration in Chiropody will meet for examination in June of each year. **Board Secretary:** Dr. Albert G. Kalin, 24453 Grand River Ave., Detroit 19, Mich.

Minnesota

The Minnesota Board of Chiropody Examiners. **Board Secretary:** Dr. Robert E. Ray, 512 N.W. Federal Bldg., Minneapolis, Minn.

Mississippi

The Mississippi State Board of Health. **Board Secretary:** Archie L. Gray, M.D., Box 1700, Jackson, Miss.

Missouri

The Missouri State Board of Chiropody. **Board Secretary:** Frank Fulkerson, 611 Clay St., Chillicothe, Mo.

Montana

The Montana State Board of Chiropody-Medical Examiners will meet when the need arises for reciprocity or examination at the Capitol Bldg., Helena, Mont. **Board Secretary:** Dr. L. M. Jennings, 411 First National Bank, Bozeman, Mont.

Nebraska

The Nebraska State Board of Examiners in Chiropody. **Board Secretary:** Herman F. Gartner, D.S.C., First Natl. Bank Bldg., Lincoln, Nebr.

Nevada

The Nevada State Chiropody Board. **Board Secretary:** Dr. William A. Edwards, 150 No. Arlington St., Reno, Nev.

New Hampshire

The New Hampshire Board of Registration in Chiropody. **Board Secretary:** Edward W. Colby, M.D., 61 S. Spring St., Concord, N. H.

New Jersey

The New Jersey State Board of Medical Examiners meets semi-annually for examination on the third Tuesday, Wednesday, Thursday and Friday of June and October. **Board Secretary:** Royal A. Schaaf, M.D., 28 West State St., Trenton 8, N. J.

New Mexico

The New Mexico State Board of Podiatry. **Board Secretary:** Morris Haas, D.S.C., 121 Sycamore St., N.E., Albuquerque, N. M.

New York

The New York State Board of Podiatry Examiners. **Board Secretary:** James O. Hoyle, Ed.D., 23 S. Pearl St., Albany, New York.

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*Combes, F. C.: Ind. Med & Surg. **30**:29-34 (Jan.) 1961.

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References: (1) Sulzberger, M. B.; Wolf, J.; Witten, V. H., and Kopf, A. W.: Dermatology: Diagnosis and Treatment, ed. 2, Chicago, The Year Book Publishers, Inc., 1961, pp. 44-45. (2) Combes, F. C.: New York Physician & Am. Med. 33:3, 1949.

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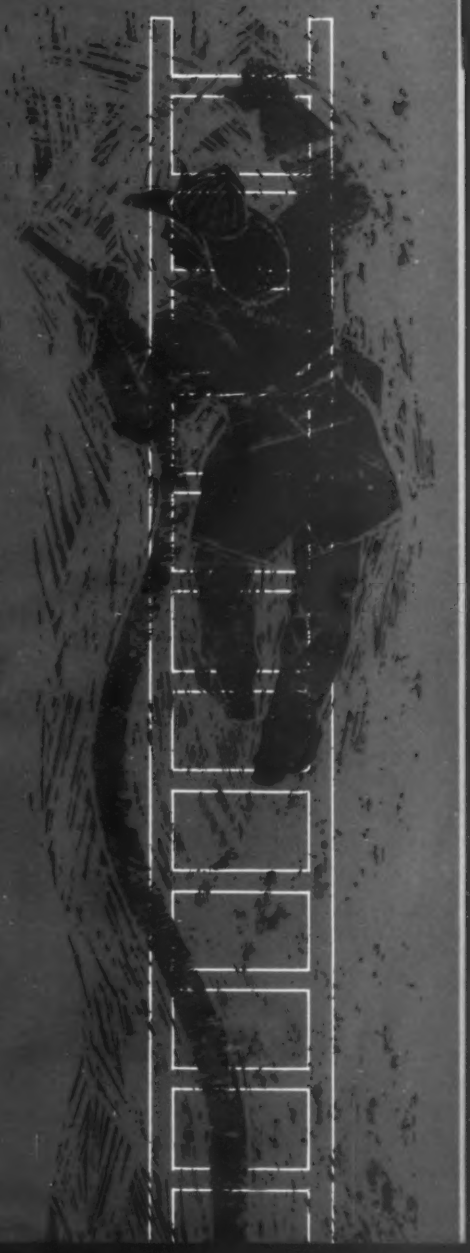

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Combes, F. C.: Ind. Med. & Surg. 30:29-34, Jan., 1961.

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State Board *(Cont.)*

North Carolina

The North Carolina State Board of Chiropody Examiners. **Board Secretary:** Robert W. Getchell, D.S.C., P.O. Box 796, Goldsboro, N. C.

North Dakota

The next board meeting of the North Dakota Board of Registration in Chiropody will be held for reciprocity and examination at call at 301 Black Bldg., Fargo, N. Dak. **Board Secretary:** Joseph E. O'Brien, D.S.C., P.O. Box 872, Bismarck, No. Dak.

Ohio

The Ohio State Medical Board. **Examiner in Chiropody:** H. M. Platter, M.D., 21 W. Broad St., Columbus, Ohio.

Oklahoma

The Oklahoma State Board of Chiropody. **Board Secretary:** Dr. Warren D. Long, 1217 No. Walker St., Oklahoma City, Okla.

Oregon

Oregon State Chiropodists' Examining Board. **Board Secretary:** Richard H. Wilcox, M.D., 914 State Office Bldg., Portland, Ore.

Pennsylvania

Pennsylvania State Board of Chiropody Examiners. **Board Secretary:** Dr. Jack S. Pincus, 26 N. 3rd St., Harrisburg, Pa.

Rhode Island

The Rhode Island Board of Examiners in Chiropody. **Administrator:** Thomas B. Casey, 366 State Office Bldg., Providence, R. I.

South Carolina

The South Carolina Board of Podiatry Examiners will meet for examination Aug. 6-10, 1962 at 122 W. Whitner St., Anderson, S. C. **Board Secretary:** Dr. James D. Hill, 122 W. Whitner St., Anderson, S. C.

South Dakota

The South Dakota State Board of Chiropody Examiners will meet at the discretion of the Board. **Board Secretary:** Viola Marr, 115 N. Main Ave., Sioux Falls, S. D.

Tennessee

The Tennessee Board of Registration in Chiropody. **Board Secretary:** Stephen A. Lamm, 3355 Poplar Ave., Memphis, Tenn.

Texas

The Texas State Board of Chiropody Examiners. **Board Secretary:** Dr. Lewis M. Hoppock, P. O. Box 3315, Temple, Tex.

Utah

The Utah State Board of Chiropody Examiners. **Board Secretary:** Ward A. Burbidge, 1015 Medical Arts Bldg., Salt Lake City, Utah.

Vermont

Vermont Chiropody Association. **Board Secretary:** Gray S. Clark, Service Bldg., Rutland, Vt.

Virginia

Virginia Board of Medical Examiners. **Board Secretary:** Russell M. Cox, M.D., 509 Professional Bldg., Portsmouth, Va.

Washington

The Washington State Chiropody Examining Committee usually holds Basic Science and Chiropody examinations the first and/or second week in January and July at the University of Washington, Seattle, Wash. **Board Secretary:** Thomas A. Carter, Administrator, Department of Licenses, Olympia, Wash.

West Virginia

Medical Licensing Board of West Virginia. **Board Secretary:** N. H. Dyer, M.D., 1800 E. Washington St., Charleston, W. Va.

Wisconsin

The Wisconsin State Board of Examiners. **Board Secretary:** Roy M. Cowen, 2018 E. North Ave., Milwaukee 2, Wis.

Wyoming

The Wyoming State Board of Registration in Chiropody-Podiatry. **Board Secretary:** Dr. J. W. Scott, 21 East Works St., Sheridan, Wyo.

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*Walker, M. H., Rubefacient therapy for the feet, *Journal of the American Podiatry Association*, vol. 50, Oct. 1960.

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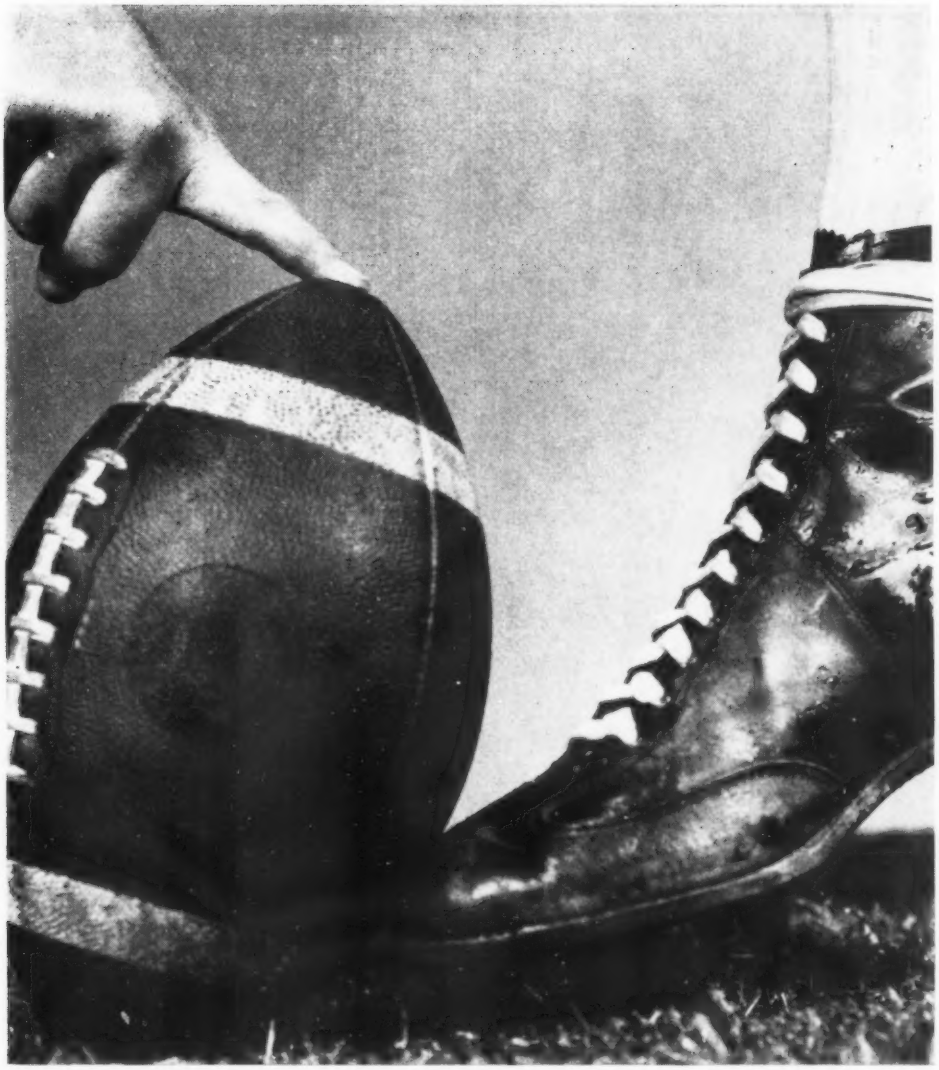

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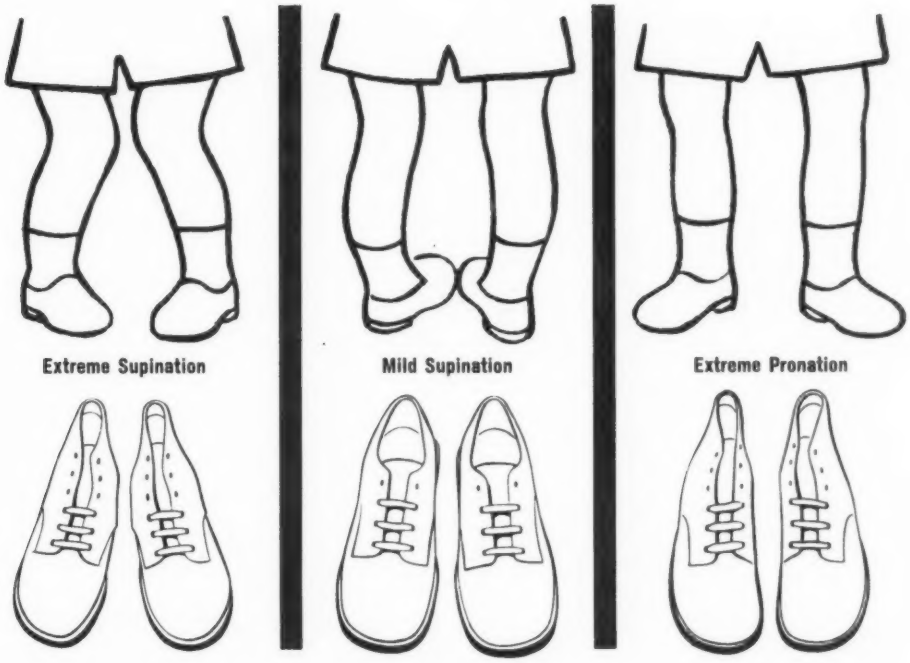

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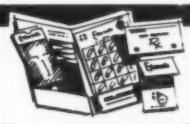

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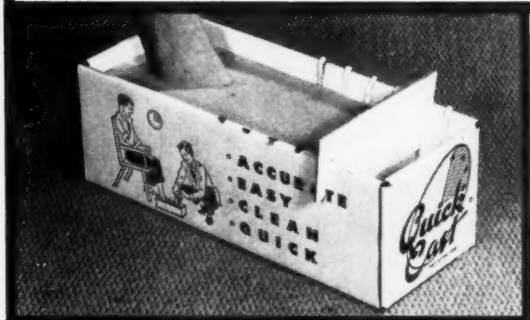

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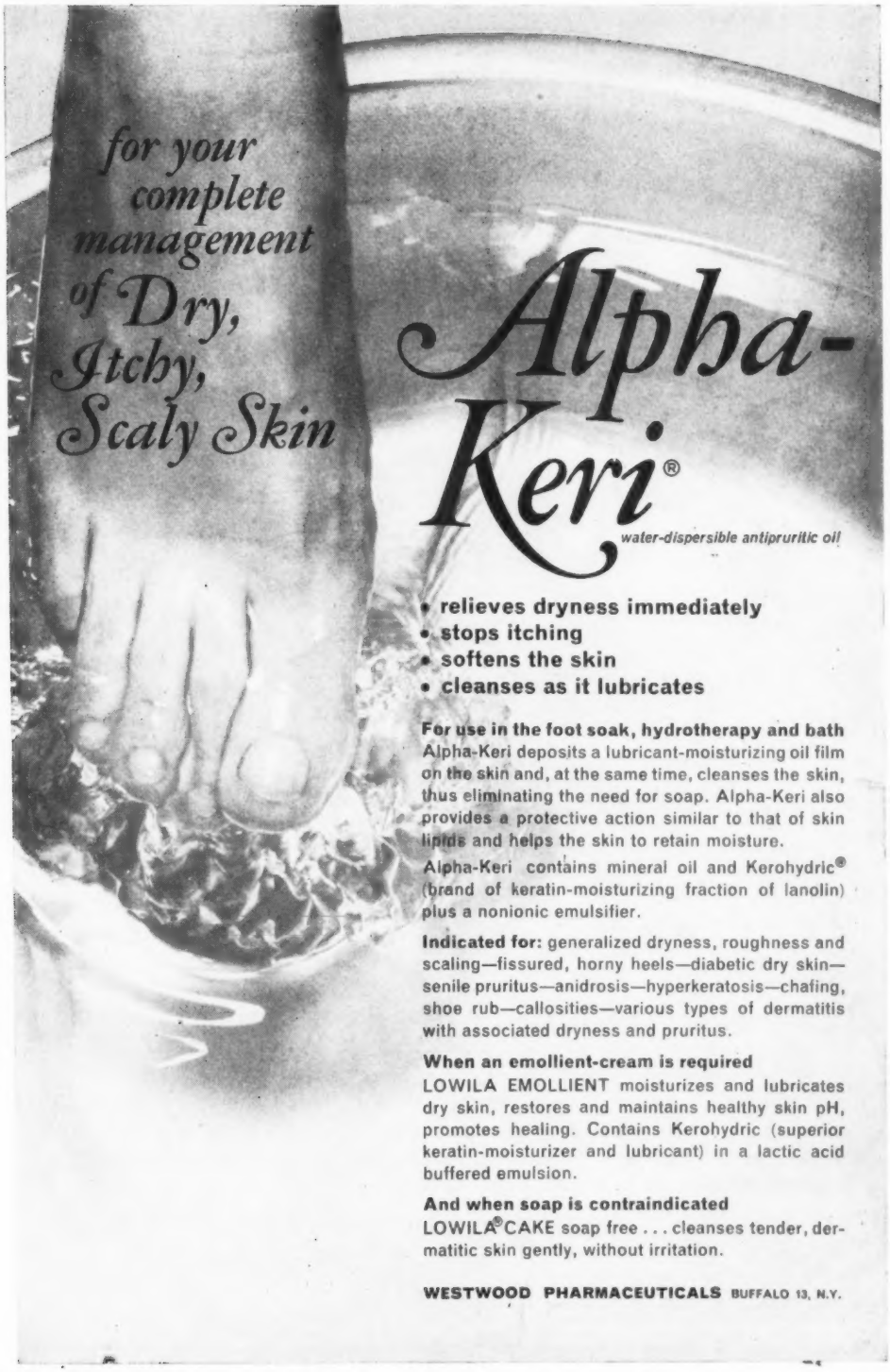
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JOURNAL
OF THE
AMERICAN PODIATRY
ASSOCIATION

The Official Publication of the Podiatry-Chiropody Profession

VOLUME 51 SEPTEMBER 1961 NUMBER 9

Rationale for the Use of Foot Appliances In the Podiatry Practice

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THE case for and against foot appliances is very old indeed and if the author were to make a thorough investigation of the literature he would find a vast array of arguments both pro and con. Since such a study is neither feasible nor practical it is the purpose of the author to present the affirmative side of the subject with occasional references to the negative views.

Dickson and Dively, in their book, "Functional Disorders of the Foot," state: "There is probably no single therapeutic measure in medicine about which more diversity of opinion is held than upon the kind of support which should be used in the treatment of static faults of the foot. Whatever the difference of opinion may be as to the best kind of support, it is generally conceded that some device which will support the arch is necessary for the successful management of a foot which is unbalanced and causing symptoms, the type of support being a matter of personal preference and experience."

Norman C. Lake, in his book, "The Foot," in discussing the treatment of flat foot writes: "There is a tremendous difference of opinion regarding the use of arch supports. . . . Usually it is considered that these should not be used unless the muscles fail to respond to treatment, lest, by enforced inactivity, muscular tonus and power be still further reduced. There can be no denying, however, that a very large number of people find the use of such supports beneficial, although whether they act by taking the strain off over-stretched ligaments or off the muscles is open to conjecture."

Dr. Henry H. Jordan, in his book, "Orthopedic Appliances," presents us with a most comprehensive review of this subject. He writes, "Because it seems so easy to go to a drug or surgical supply store to buy a pair of foot plates for any of the many ailments which afflict the feet of civilized man, many physicians have apparently assumed the attitude that it is below their dignity to prescribe such appliances." We might add to Dr. Jordan's comments that far too many podiatrists assume the same attitude. As a direct consequence of this rather peculiar position we will try to review its economic consequences later in this report.

To discuss this entire subject in a com-

prehensive manner it may be well for us to ask ourselves several pointed questions about the subject of foot appliances that need answering.

1. What are the primary objections raised to the use of foot appliances and what is the validity of these objections?

2. Are podiatrists adequately trained in the construction of foot appliances and their proper application to foot problems?

3. When, where and how should foot appliances be used?

Let us take up the first question based on the objections to foot appliances, real or imaginary.

The objections to foot appliances, and more specifically metal appliances, voiced most often by podiatrists, is that such devices cause atrophy of foot structures. Gould's Medical Dictionary describes "atrophy" variously as, "a wasting of a part from lack of nutrition," or, ideopathic muscular atrophy as, "a progressive wasting of groups of muscles depending upon primary changes in muscles themselves." It is the contention of the author that no podiatrist has ever conducted a scientific inquiry into the subject of atrophy of the plantar foot structures.

In 1936 the author conducted a survey on the effects produced by the wearing of metal appliances. All patients who presented themselves to the diagnostic clinic associated with the Foot Clinics of Illinois at the Illinois College of Chiropody during that year were included in this survey if they were wearing metal foot appliances, no matter what the type or where they were obtained. The object of the survey was to determine from these patients whether or not they had observed loss of tissue on the plantar of the feet as the result of wearing such appliances.

More than 10,000 patients registered at this diagnostic department during the year and of that number more than 300 were wearing some type of metal arch supports. The vast majority of these were of the commercial type and the length of wearing time varied from several months to 30 years.

Our final tabulation of figures demonstrated to us that there was no correlation between loss of plantar tissue and the wearing of such appliances, because we actually found more evidence of plantar tissue loss among an equal number of those patients who never wore appliances of any type. In re-evaluating those findings in the light of this discussion, the author must admit that all deductions on the type of tissue loss observed were made without benefit of science and by observation only. We set up no standards of criteria for scientific studies. Yet, from such a point of view alone, and it is the same view that is expressed by all podiatrists, the findings were interesting.

Let us determine, if we can, whether or not there is a scientific basis to the claim that foot appliances will cause atrophy of plantar tissue. Physics teaches us that there are five types of stresses that can affect our foot structures and of all these various stresses those known as "compression stresses" are directly concerned with plantar foot changes. Again, there is a positive physical law which states that under constant pressure of an unremitting type, living tissue will atrophy, while intermittent pressure will cause living tissue to hypertrophy.

Since the very act of walking calls for pressure or compression of only one portion of the foot at any single moment while the opposite foot is swinging through the air without any direct pressure, only forced weight bearing in a fixed position for a long period of time could possibly cause atrophy. In fact, most patients in our experience find that their feet become more swollen and hypertrophied as the day wears on. It is this hypertrophy which is the active etiology in the formation of excrescences associated with stresses caused by shearing, bending and torsion with the shoe as the offending medium.

The action of the foot encased in a plaster of Paris splint for a period of time will also bear out this thesis. When the cast is removed after a period of weeks or months, there is always atrophy present. Therefore, because any foot plate is in contact with the

plantar of the foot on an intermittent basis, there is no substance to the objection that foot plates cause atrophy of the plantar structures. In fact, they cause no more atrophy than could be caused by the wearing of foot gear alone.

Dr. Jordan, on this point, says, "A properly made plate . . . need cause no greater damage to the foot than is caused by the cultural factors of the modern shoe and of the solid plane or even ground. . . . If the comparison be permitted, I should like to say that from every angle the use of foot plates does not inconvenience the patient as much as the wearing of a dental plate, provided that the indications for the foot plate and the foot plate itself are correct."

There is another objection that always creeps into my discussion of foot appliances. Someone is quite ready to say that a foot appliance acts like a crutch and once it is used it must be continued indefinitely. If foot appliances are necessary and the proper appliances have been made, the length of time that they are used is of no consequence. The same people who raise this objection never consider their own glasses or dental prosthetics in the same light. Finally, a crutch can be a very useful and important device when it is needed.

An appraisal of the second question is now in order. Are podiatrists adequately trained in the construction of foot appliances and their proper application to foot problems? We must compare our training in the mechanics of our profession with that received by the dentist or the optometrist. Using that training as a basis, I must conclude that we are not well trained at our schools or after we leave school. From my own observations I must conclude that we do not offer a single course at any of our schools that compares with similar courses in mechanical dentistry.

Our graduates have had insufficient practical experience in the construction of the various types of appliances, nor have they been able to apply these appliances clinically in more than a very few instances during their clinical practice. I know of no single school of podiatry that instructs students in the fabrication of metal appliances. In fact, there are many students at our schools who have never made or prescribed a single pair of appliances. Some of you may be surprised by these statements, but I know that most of you who have graduated from our schools during the past 15 years are well aware of this situation.

If you are to assume that I and others in the podiatry and medical professions are correct in our contention that many of our patients require foot appliances as part of their regimen of total foot care, how can we provide such appliances with any degree of scientific accuracy unless we are fully trained to do so? We can be fairly certain that a very large percentage of practicing dentists will agree that prosthetics are essential to their practice. We can be almost as certain that an equally large percentage of practicing ophthalmologists will agree that the prescribing and fitting of glasses is most essential in their practice. How many podiatrists would agree to the same premise for devices used in their profession?

Again, let us quote Dr. Jordan on this subject. He writes, "We shall find that the construction of efficient foot plates is a difficult task which requires a thorough knowledge of the subject on the part of the physician and of the skilled, well-trained brace maker in a properly organized workshop. . . . We shall see further that an understanding of the action of foot braces on the foot and on the relation of the foot to the entire body is by no means common knowledge, and that it is a wrong conception of what a foot plate should or should not do, which is mainly responsible for the disrepute into which these appliances have, on the whole, fallen. There is no doubt in my mind that foot braces are necessary and that they constitute the most frequently used and one of the most valuable orthopedic appliances."

Ultimately there can be only one solution to the problem that spells out our lack of knowledge of foot appliances. That solution must be found in our schools.

Those of us who are no longer able to return to our schools to take advantage of the work that may be offered in the future will have to demand a number of lectures and demonstrations on appliance therapy at all of our meetings from now on. I am not referring to a display of newly developed techniques and new practice methods. I am referring to the basic fundamental principles on which I will touch when answering the next question.

That brings us to our third question, "When, where and how should foot appliances be used?" Some years ago, the author published a paper which included five basic principles in the philosophy of podiatric practice. My fourth principle stated, "Whenever treatment designed to bring about a change for the better is not continued for a long enough period of time, or with too mild a degree of force, the change desired will be temporary only and the structures will revert to their genetic tendencies."

No matter how well intentioned we are in our treatment of our patients, we cannot spoon feed them hour after hour, day after day and week after week. Those of us who have mastered foot appliance therapy have found a very efficient method for maintaining correction and alleviating symptoms from the very start of treatment. Now you have one of the methods that I employ with every chronic foot imbalance that appears in my office with very few exceptions. I believe that it is imperative for the well being of my patient that I construct the foot appliance that will be most efficient very early in my treatment program.

In my text book, "Mechanical Foot Therapy," in a chapter on Balance Therapy, I state, "A balance appliance or inlay can serve but one basic purpose—the alignment of the foot to the walking surface and the leg so that more normal function will result." Since "structure follows function," beneficial structural changes will take place if the appliance is made and used correctly.

In another chapter under "Indications for the Use of Metal Appliances," I list five basic conditions when such appliances could be used beneficially:

1. To support foot structures that have been distorted by crushing injuries.

2. To support foot structures with congenital structural defects.

3. For children of all ages whose structural or muscular instability is of a primary nature above the first horizontal plane of the foot.

4. Excessively overweight adults for all types of foot conditions requiring supportive therapy.

5. As a supportive measure for the care of fractures of tarsal, mid-tarsal and metatarsal bones.

Dr. Jordan, in his discussion on the indications for foot plates, lists the following reasons for their uses:

1. For prophylactic purposes,
2. As a means of correction,
3. As a foundation and support.

In his development of the first statement, Dr. Jordan writes, "A foot plate should be worn for prophylactic reasons as soon as subjective signs of fatigue or pain on standing or walking manifest themselves, the gait becomes unstable, or the patient complains of frequent 'turning over' with his foot or even sprains of the ankle joint. . . . In patients who have no subjective symptoms, the prophylactic use of plates is indicated if there is a marked increase in body weight, such as pregnancy, in endocrine or alimentary obesity, after fractures of the foot or leg, following operations on the extremities, in cases of vericose veins in poor bodily carriage, and finally after prolonged rest in bed necessitated, for example, by chronic infectious disease."

On point number two, Dr. Jordan states, "As a means of correction a foot brace is indicated wherever examination shows a deformity of the foot or a faulty static alignment of the extremity regardless of whether the pathologic condition has already caused clinical symptoms or whether it has been discovered accidentally. . . . This group of

cases which necessitate the corrective action of a foot brace is by far the largest and includes pes planus, pes valgus, pes transverse-planus, the possible combinations of these three components in various degrees, and deformities of the metatarsals and the toes such as hallux valgus, hammer toe, hallus rigidus, and others which sooner or later may follow the primary malformation or malposition of the entire foot.

"All the cases mentioned in this group have in common the need for correction of the foot's position, while there is little or no need for support. For the indications in this group to be fulfilled flexibility or relaxation of the foot in all its sections is essential. This means that it must be possible to convert a rigid foot into a flexible or relaxed foot before a correcting foot brace can be built and applied."

In consideration of the third indication for foot plates, Dr. Jordan states, "The third group of indications for a foot brace represents cases in which pain and insufficiency require support for the foot but in which there is no possibility of correcting the pathological condition by conservative or operative measures. The end-results of corrective procedures for paralyzed feet or for congenital deformities, ankylosed feet following infectious arthritis or osteomyelitis, belong to this group; also the rigid pes plano-valgus, etc. in patients who cannot stand or who for various reasons refuse corrective measures. The prime purpose of foot plates in these cases is to effect a correct, painless distribution of weight and to establish as far as possible the correct position of the elements of the foot in relation to the line of gravity of the leg."

In this series of statements we have a very comprehensive outline for the use of foot appliances. Having attempted to answer the questions when they should be used, I will try to answer the question of how to use foot appliances.

The question "how" should really refer to the type of foot appliances that would be most appropriate or beneficial for certain specific conditions. It should also refer to the multiple factors that are associated with the construction, fitting, patient's cooperation and repair of foot appliances. No single paper could possibly cover a subject of such magnitude but we will try to approach some of the aspects relating to these problems.

It is the opinion of the author and one that is totally substantiated by Dickson, Dively and many other authors that all foot appliances should be made for the entire foot and not just for a segment of the foot. The foot as a total structure requires aid when any single part is affected adversely.

The type of appliance to be used can vary considerably depending on the background and experience of the doctor. However, here also, most authorities agree that foot appliances should be constructed over models of the feet that have been taken with great care and purpose. The convenience of the doctor should never become a major factor in his decision for or against a plaster model. Only the welfare of the patient should remain as the final consideration.

Furthermore, no appliance can be much better than the skill and preparation that enters into its construction. In most instances the skill of the doctor ends with his diagnosis and directions to the bracemaker, for the bracemaker does not have the knowledge or the clinical experience of the doctor, but neither has the doctor the facilities nor the mechanical aptitude of the bracemaker. Each has his supreme sphere and certainly each serves his purpose. Together they make up a team that cannot be surpassed for the benefit of the patient.

The decision to use rigid or flexible appliances should never depend upon the doctor's prejudicial attitude or his simple preference to always use one type for all problems. Earlier in this paper we named specific conditions where the use of metal therapy was indicated and other conditions that would respond best when flexible appliances were used. The construction of metal appliances requires a considerable amount of equipment and a great degree of skill. Very few podiatrists have the facilities or the capabilities for constructing metal

foot appliances. However, all podiatrists should have the simple equipment that it takes to adjust or modify such appliances and they should learn the methods used to bring about such adjustments. All that is required is a good vise, a lead block, several peen head hammers and a rawhide hammer. Your bracemaker will be happy to give you the necessary instructions that will enable you to make most of the modifications required.

While many podiatrists construct their own appliances from ready-made shells, forms, fillers and a vast variety of materials that can be poured, moulded, baked or ground out, I have seen very few finished products that bore much resemblance to, or could fulfill its purpose as well as a professionally constructed foot appliance. Most doctors have neither the time nor the skill that is needed to produce work of professional quality. We become incensed when our patients indulge in bathroom surgery, yet we ask our patients to accept foot appliances that are amateurish, at best.

Fitting the appliance to the foot and the shoe and directing the patient in the use of the appliance is in itself an art. It is my belief that many doctors become discouraged with foot appliances very early in their practice because they do not understand the nature of this problem or how to handle it. It is questionable whether there are any shoes on the market that are ideal for the use of appliances. Since that is true, it becomes the task of the doctor and the bracemaker to understand the shoe problem and to construct the appliances so that they will take up a minimum amount of space in a well fitted shoe.

The following factors must be taken into consideration when we consider shoes as a housing for foot appliances:

1. New appliances should be worn in new shoes only for best results.

2. Recently purchased shoes may be used only if they are of the proper last and fit the foot very well.

3. The heel height must conform to the construction of the appliance. This is especially true when rigid appliances are fitted.

4. The shoes must be cut high enough at the quarters and must have a pear-shaped heel seat and a narrow back last.

5. Shoes must never be too long or too short.

6. Extra depth shoes have some additional value when bulky foot appliances must be fitted.

7. The shank of the shoe must be wide enough to support the base of the appliance without spreading the shoe.

The shoe is only one factor that must be considered in the broad subject of careful fitting of foot appliances. When the appliance has been completed and the patient is ready for a fitting, the following steps will insure the best results.

1. Apply the appliance to the foot off of weight bearing and check to make certain that all of the landmarks of the foot are properly contained within the appliance.

2. Check for any possible pressure points or areas of irritation—especially with metal appliances.

3. Repeat procedures one and two with the feet assuming partial weight bearing.

4. Take the appliances and the shoes to your laboratory workshop, out of the patient's view, and fit the appliances to the shoes. All shoe adjustments and appliance adjustments relating to this important fitting must be made at this time.

5. Have your patient put on the shoes with the appliances and allow the patient to walk with them for about five minutes. After that time if there are no major problems, do not rush to make any further changes at this time.

6. Instruct your patient to wear the appliances in the shoes for which they were fitted for no more than two hours at any time for the first few days. The wearing time may be increased each day if no problems develop. If the patient is employed, it is best to wear them at home or on weekends for the first few days.

7. The patient must be instructed to call the doctor if any difficulties are experienced in carrying out these instructions. If there are no difficulties the patient is instructed to return in two weeks. When problems arise, the patient must be seen at an earlier date.

8. When the patient returns to your office make those adjustments that you can and know how to make. If there are major changes to be effected, return the appliances to the laboratory for such alterations.

9. All of the above directions relate to the fitting of foot appliances for adults only. Most children require very little alteration to their appliances and in most instances they can walk out with their appliances with little or no discomfort. This is as true with the fitting of metal appliances as it is with appliances made with more flexible materials.

Finally, we must consider the intelligent use of the appliances by the patient. Since no doctor can follow his patient and concern himself with all of his patient's activities, this factor in the rationale of foot appliance therapy becomes a most important one.

The patient must be given specific information about the use of his appliances, and since most people remember very little about what they are told verbally, it is best to prepare a printed list of instructions. Here are some of the items that may be included:

1. Your appliances were scientifically conceived and constructed for your feet and they will not be of any value to any other person. Like your dentures or your glasses, they are precision devices.

2. Never make any repairs or changes on your foot appliances or allow anyone other than a podiatrist to make such changes.

3. Since feet can undergo drastic changes as the result of illness, mechanical abuse, increase or loss of body weight, improperly fitted shoes and for numerous other reasons, your appliances may require adjustments to compensate for these changes. Let your podiatrist be the judge of such requirements.

4. As long as you are wearing appliances make it your business to have all of your new shoes checked by your podiatrist. He alone can advise you on the proper fit of the appliances in your new shoes.

5. Since foot appliances receive far greater abuse than any other prosthetics, such as dentures or glasses, they must be inspected regularly. Make certain that your podiatrist checks them at least once every six months so that he can keep them in good repair.

6. Because of this great amount of wear and tear on your appliances it will be necessary to replace them from time to time. If your feet are performing efficiently, return to your podiatrist for a re-evaluation of your problem before you decide to go without appliances or to use some substitute which may cause considerable damage to your feet.

Before concluding my thesis it may be well to point out a few facts on economics relating to foot appliances. In projecting the figures supplied by the A.P.A. Council on Professional information as published in the October 1960 issue of the *A.P.A. Journal* (item number 45), we find that all podiatrists in the United States used approximately 150,000 pairs of foot appliances in their practice during a 1-year period. If this were broken down it would mean that each podiatrist used less than 20 appliances a year, or less than two pairs each month.

Let us compare this to the most interesting statement that has been fairly well authenticated, that between two and three million pairs of commercial appliances are sold in the United States each year. The American citizens would be insulted today if they would be confronted at the average department store with a counter full of dentures for individual fitting or eyeglasses for the same purpose. And yet, every department store in your community displays and encourages the sale and use of foot

appliances of every conceivable description.

How many times a week do you see your own patients in the privacy of your own office remove their shoes containing a pair of these commercial devices? It is my contention that every time you see such a patient it is a severe indictment of your own inadequacy or that of some other podiatrist who treated that patient last.

Whenever a patient purchases a commercial foot appliance they do so only because they are attempting to obtain more comfort or more correction than we have been able to offer. The fact that we are committing economic suicide by ignoring this vital area of our practice is almost beyond the comprehension of any sensible business-minded professional man, but of greater importance by far is the fact that we are allowing this important area of therapy to remain in the grip of the commercialists and we are entrusting our patients to their mercy by the thousands every day of the year.

In conclusion, may I repeat that I have attempted to develop the rationale for the use of foot appliances from all of its possible aspects. The scientific and intelligent use of foot appliances will be of considerable benefit to our patients and can enhance the position of the podiatrist in many ways.

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"Neither should we attempt to cure the body without curing the soul."

—*Plato 427-347 B. C.*

The Foot in Transient Synovitis of the Hip*

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It is the purpose of this paper to describe transient synovitis of the hip and its relation to the foot and illustrate the condition by a case report. To the best of the author's knowledge, the treatment of synovitis of the hip affecting the foot has not been reported in our literature.

It is probable that injury at the hip-joint, wherein the synovial sheath becomes inflamed, irritated and congested, produces a synovitis of the hip. When this synovial sheath is affected and there is no evidence of the presence of pus, the condition is termed transitory synovitis. This congestion, with diminished local resistance induced by it, may result in a limp and restriction of motion.

Synovitis can attack any joint. It may be due to infection or trauma. When it affects the hip it is commonly referred to as transitory synovitis. Transitory synovitis is associated with trauma, upper respiratory infection, and inflammatory conditions in children associated with contagious infection.

The characteristic signs in transient synovitis of the hip are a steppage gait and a limp, commonly referred to as a psoatic limp, in which the femur is maintained in external rotation, flexion, and abduction, wherein tension on the ilipsoas muscle is minimal. Pain is the accompanying symptom. Together with these two important criteria are negative X-ray findings.[1,2] There are no bony abnormalities to be found. In some cases capsular swelling is seen on the posterior and lateral aspects of the acetabulum. The epiphysis is not altered. X-rays do have a value by excluding Perthe's Disease when there is no evidence of destruction in the epiphysis.

The etiology of this condition is unknown but it is thought to be associated with trauma or infection. There may have been a history of a recent upper respiratory infection a history of allergy or a history of trauma to the affected side. Spock's[3] studies show that there may have been a recent active infection of the respiratory tract and that perhaps a variety of infectious agents were responsible for the syndrome, especially beta-hemolytic streptococci and B virus.

Although a number of papers[4-15] have been written on transient synovitis of the hip, Spock's paper summarizes and correlates much of the information on this common affection of children. Spock concludes that the condition occurs most commonly in children up to 7 years of age; males more frequently than females and rarely negroes; disease has an acute onset—symptoms are usually present on 1 to 3 days before medical care is sought. Predominant symptoms are limp pain or both. Pain may be localized in the hip, thigh or knee. Either hip can be involved but the right more frequently than the left and examination reveals patient to appear well; sometimes acutely or mildly ill. Two-thirds have an upper respiratory infection, and patients are frequently obese and stocky. A slight elevation of temperature may be noted. All patients exhibit definite but varied restriction in passive motion of the involved hip joint and limp is usually present. Average duration of illness, 13 days; disease is self limited but occasionally there are reoccurrences. Few patients develop Leg-Perthes Disease and X-rays of the hip are useful in excluding other pathological conditions and are not helpful in the diagnosis of transient synovitis of the hip. In Spock's report of a series of 47 patients, normal bony texture was found in 47 cases.

*Presented at The Scientific Meeting of The Academy of Podiatry, New York City, December, 1960.

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Treatment for both acute and chronic cases require complete bed rest and antibiotics for any infection present. Mild sedation as required and acetylsalicylic acid are recommended. When pain is marked, fixation in traction, followed by a plaster cast may be advisable. Synovitis is not in itself serious and usually clears up rapidly.

Case Report

S.A.B., a 7-year-old, weight 58 lbs., ht. 4 ft. 2 in., well-nourished male, was brought in for examination. Approximately 3 days before the examination, the mother noted the onset of pain in the left hip on weight-bearing and in motion. She noticed that the child had begun to limp and walk peculiarly. There was no history of an injury, not even a trivial injury. There was a possibility that his older brother, age 11, had playfully injured him. When the child complained that he was unable to walk, podiatry care was sought.

Past Medical History

Patient had usual childhood diseases: mumps, German measles, chicken pox, and a history of allergy. The child has been receiving weekly desensitizing injections. There was a history of infected sore throats for the past 3 years. Just 6 months prior to office visit tonsillectomy was performed on child. Child had received regular immunizations.

Physical Examination

The patient's temperature, pulse, blood pressure and respiration were sound. The patient was a pleasant, cheerful and bright child, who did not appear acutely or chronically ill. He was in moderate discomfort and was somewhat disabled by the pain in the hip. Motion of the hip joint caused increased discomfort. A full range of motion could not be performed by the patient. There was some restriction of external rotation but marked limitation and restriction of internal rotation. The child was tested for tension by determining the degree of abduction that was possible. The child was placed supine on the examining table. It was possible to spread the unaffected leg, while hip was flexed to 90 degrees (within normal range of motion), so that the thigh lay flat on the table. With the affected limb this was not possible. There was approximately a 15 degree limitation in abduction from the table. During ambulation across the examining room, the leg was externally rotated and slightly flexed. The knee was flexed and the foot planted flat on the ground. As a rule this is the general position of the foot (rarely, however, the foot may also be held in talipes equinus). Accommodation was made by mild flexion and external rotation of the hip. A stance and gait analysis according to Schuster[16] revealed the following:

	Left	Right
Tibial Prominence To Internal Malleolus	11″	11″
Leg Relationship a.p.	¾″ between ankles	

This represents a 5 degree knock-knee attitude but is not significant.

Scaphoid Differential	2/16″	2/16″

Within normal limits.

Achilles Angles	9 deg.	1 deg.

Left reading was beyond average indicating inverting therapy was required, though findings may or may not be related to hip.

Forefoot Diff.	3 deg.	1 deg.
Foot Elongation	2/16″	2/16″

Both were within normal limits.

Metatarsal Splay

Left was slightly beyond average, but not significant.

Stance Angle	8 deg. intoe	
Gait Angles	5 deg. intoe	0
Length of Stride		14″

All of above were not significant.

Width of Stride from Center of Heel to Center of Heel	4.5″

This was wider than average and may have been related to the hip condition.

The remainder of the physical examination was unremarkable. Laboratory investigation revealed a normal hemoglobin,

sedimentation rate, white and red blood count and differential white cell analysis. The urine was within normal limits.

Clinical Course

Several diagnostic possibilities were considered. The child was referred to an orthopedist where a diagnosis of synovitis of the hip was made. X-ray studies of the hip revealed no pathology. The diagnosis was made after ruling out the varied hip possibilities. The child was instructed to remain in bed for 2 weeks, when follow up roentgenograms of the hip were found to be normal. The child remained in bed for another 2 weeks and was then completely asymptomatic.

After consultation with the orthopedist, an appliance was made for the child on his recovery. A steel Shaffer plate, with an outer flange and a heel wedge on the inside of the left plate was constructed. Since the left heel everted 9 degrees, which was beyond average, inverting therapy was indicated and a wedge was applied to the heel of the left plate at its medial margin.

The child was re-examined for gait and stance 6 months from the first visit and although there was no reoccurrence of his hip condition, new readings gave clue to his recovery. The width of his stride had decreased to 3 inches, which was average for this boy. This was a sign of improvement, since width of stride increases when there is a pain factor. The length of stride was now increased to 18". The child walked with more ease. During the original examination, extension was limited in left leg. When the child walked, his left leg did not go as far back as the right leg and the extension in the left leg was 1½" shorter than the right. In this examination the steps were equal in length. This was undoubtedly related to the hip pathology. Whereas the gait angle was 5 degree left intoe in the initial examination, it was now 5 degree outtoe in the left foot. The hip pathology had apparently caused the intoeing and now there was a change since the foot was relaxed. There were new readings for the Achilles angle of 4 degrees on both right and left foot. This was an improvement, inasmuch as the norm for a child of his age is 6 degrees.

Conclusion

Transient synovitis of the hip represents a problem for the orthopedist. Because of its frequency of occurrence it should be recognized by the podiatrist and proper referral made. A diagnosis of synovitis of the hip cannot be made by us until all other varied orthopedic possibilities have been ruled out.

(The author wishes to express his appreciation to Arnold Spiegler, M.D., for his advice and consultation with referred patient and gratefully acknowledges the cooperation and assistance of R. O. Schuster, Pod.D., for his interpretation of the foot examination in this case, and is indebted to both for their review of this paper.)

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Some Comments on the Fundamentals of Foot Physiology

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In this era of increasing physiologic emphasis, all fields of applied medicine are more concerned with function as compared with an earlier period of anatomic interest.

Performance, not appearance, is of primary concern to those who pursue the physiologic approach. The human foot is a machine but it is also an organized aggregate of living tissues which require adequate circulation, nutrition, and innervation for the purposes of basic metabolism, growth, repair and regeneration. These fundamental processes are the components of general physiology in distinction to other special, superimposed functions which characterize and identify the "special physiology" of the part.

It is with regard to the special physiology of the human foot that we podiatrists are especially concerned. The modern podiatrist is emerging as the health guardian of the peculiar foot mechanism—a specialized organ of the musculoskeletal system. In order to maintain its claim to a distinct specialization, the podiatry profession must investigate and demonstrate the distinctive functional characteristics of the human foot which demand its special training and interest.

The human foot is structurally and functionally adapted for maintaining efficient patterns of variable static and kinetic resistance to corresponding body demands and activity.

As organs participating in the maintenance and preservation of a relatively static body attitude, as in normal stance, the two feet supply a considerable basal area for body support and stable equilibrium. In walking, each foot alternately serves as a dynamic balancer and resolving agent of both the usual and unusual moments of gravitational force. The intrinsic mobility and resiliency of kinetic foot action occurring in gait is approximated by, and observable during, one foot step.

The ensuing is devoted to a superficial description of static and kinetic foot function with particular emphasis upon the special physiology underlying such capacity.

Static foot function is primarily supportive in nature with balancing demands reduced by the innate stability of "bimelic" stance. Though continuous minor displacements of body position require perpetual, tonic postural readjustment under proprioceptive direction, it can be said that foot alignment is maintained with but minimal muscular effort and energy expense. The unremitting burden, however small, may at times exceed safe limits of duration with the resulting onset of muscular fatigue and fibrofascial "strain," the consequence of disturbed static equilibrium.

Optimal bone-joint configuration and static alignment has been minutely detailed by Felton Gamble[1]. We must insist, however, that static foot function is physiologic, not morphologic, and that the latter criteria must be employed as a basis, not a system, for static evaluation of clinical disorders. Gamble recognizes the limitations of morphologic data when he says "An apt clinician will utilize every diagnostic consideration in evaluating the status of foot orthopedic problems."

Upon the knowledge of morphoanatomic normalcy can be superimposed the physiologic concepts of Dudley Morton[2] who has interpreted the human foot as a specialized mechanism for the "refractive" utilization of gravitational stress. The controlled interaction between imposed and responsive foot forces is the physiologic basis of specialized function by this organ.

An improved knowledge of the component forces which normally subserve static alignment and equilibrium will yield huge rewards in the clinical future.

Kinetic foot function embraces the more dynamic aspects of controlled mobility

evidenced in normal gait, as well as in more vigorous locomotor activities.

In walking, the overlapping sequence of alternate limb support indicates a relative independence of kinetic foot action. Interdependence cannot be denied when the over-all gait pattern is surveyed, but each foot executes a kinetic routine involving body reception, transmission and propulsion, in a somewhat independent fashion.

Whereas the intermittent contact area of single foot support is much narrower than that of "two foot" stance, there is a comparable reduction of and need for collateral body stability in gait. Forward body momentum reduces the need in collateral security in the same way that bicycling balance is enhanced through forward acceleration.

Diminished collateral stability in gait, however, is not a weakness or deficiency as it might initially appear. The instability is supplanted by controlled foot mobility in the mediolateral plane. Inversion and eversion are the pedic postural expressions of such mobility. Not only do they serve to maintain a balanced relationship between foot and body, but they allow the smooth transition of body "facing" in the alternating directions of intermittent support. Axial torso-limb rotation toward, then away from, the supporting foot is resolved by foot postural fluctuation from inversion to eversion[3].

Too long have the collateral foot movements received only pathologic notoriety from the profession. It must be recognized that these intrinsic postural variations are not entities, fit only for therapeutic confinement. These are singularly human features which distinguish the foot of man and permit him his graceful, upright terrestrial stride.

The human foot is an organ of distinctive mechanical function. Foot function is specialized by virtue of its capacity for efficient, variable resistance to its gravitational burden. The dual nature of the foot as an instrument of both static and kinetic design, exposes it, under civilized abuse, to a multitude of debilitating factors, and explains its extreme susceptibility toward derangement.

In stance, the feet are remarkable in that they maintain body support and balance for extended periods without undue muscular effort, energy output, or fatigue. Normally, they possess a marked reserve capacity which, however, may be reduced by such factors as poor posture, over-weight, illness, and inherent predisposing mechanical defects.

In gait, the feet reveal extraordinary kinetic capacity by means of which dynamic support, balance, resiliency, and propulsion are derived. The resolution of body motions, especially those of rotational nature, has not received adequate attention as a specific factor in foot capacity. Most authors, dealing with foot action in locomotion, have depicted the organ as but a rigid lever which propels the torso forward. As a result, the intrinsic, kinetic potential remains largely an unexplored area in foot physiology.

48 East Central Street

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The Therapeutics of a Surface Analgesic for Musculoskeletal Problems of the Lower Extremities*

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EVERY text on management of musculoskeletal disorders associated with pain recommends some form of physiotherapy. Massage has long been prescribed as one of the modalities of physical medicine.

A question arises as to the benefits obtained with massage. Is it the hyperemic effect of the massage alone that relieves the pain? Liniments are prescribed generally for their rubefacient, counter-irritant, mildly astringent and penetrating effects.[1]

Many fat-soluble preparations are absorbed through the skin. The fat-soluble agents usually used are: methyl salicylate (oil of wintergreen), turpentine, mustard, thyme, camphor, rosemary oil, cinnamon oil, menthol, phenol, capsicum, chloroform, ether, eucalyptol, plus all the local anesthetics of caine derivatives.

The amount of absorption through the skin has caused varied discussions since musculoskeletal pain is usually deep-seated. The nerves leading to the tendons and muscles must be reached to alleviate the pain.

Spraying an area with ethyl chloride or infiltrating the area with local anesthetics usually relieves the pain.

By incorporating 30% methyl salicylate and 3% benzocaine in a special fat-soluble amine in an aerosol form, it was found that greater penetration through the stratum corneum could be obtained. Gordon & Haas,[2] in an intensive study of chronic musculoskeletal conditions found that, in conditions such as osteoarthritis and rheumatoid arthritis, painful healed fractures, low back pains, rotator cuff tendonitis, fibromyositis, sprain of joint, tear of muscle and costoscapular syndrome, which did not respond to whirlpool bath, heat, massage and diathermy, 85 to 90 per cent responded after treatment with Ger-O-Foam.®[1]

Anesthesia obtained with the product is such, that when different degrees of water in a test tube are applied to the skin after massaging with the preparation, the patient finds it difficult to distinguish between varied degrees of heat and cold. However, there is no impairment of sensory feeling to pin-prick.

When the medication is massaged into normal tissues no feeling of warmth is recognized. However, if massaged into painful areas, a degree of warmth is obtained. It is theorized that the degree of heat obtained with Ger-O-Foam is proportionate to the degree of involvement of the afferent and sensory nerve endings. In pathologically affected areas the nerve endings carry their impulses faster to the brain. It has been clinically proven that the application of Ger-O-Foam to affected areas gives a sensation of warmth with marked relief of pain.

When the size of two golf balls of the Foam (which contains 1/60th of an ounce of methyl salicylate) is rubbed into the back from the base of the neck to the coccyx, the patient will have blood levels of salicylates.

Therapeutic Trials

As a podiatrist, I attempted to adapt the aerosol analgesic for use in the lower extremities. Various foot and leg problems were treated with proper physiotherapy measures and the mentioned product. Among these were: myositis, tendonitis, painful healed fractures, fibromyositis, calcaneal spurs, strained plantar fascia, Morton's neuralgia, ankle sprain, hallux limitus and hallux valgus.

* Paper Submitted to The William J. Stickel Annual Awards for Research in Podiatry-Chiropody for 1960.

®1 Geriatric Pharmaceutical Corp., Bellerose, New York.

Myositis: Physiological experiments are on record proving that massage applied to a resting muscle increases its power for work and retards fatigue.[3] In conditions of inflammation of muscles, especially of the gastrocnemius group, massage with Ger-O-Foam increased muscular tone and stimulated the venous and lymphatic circulation, carrying away some of the waste products. Some 40 applications of the surface analgesic were applied to eight cases of myositis of the calf muscles or arch of the foot or muscle spasm of the big toe. Frequently physical therapy measures in the form of heat preceded the massage. In each case the myositis or myofascitis due to imbalance or overactivity were greatly relieved.

Tendonitis: Trauma in the form of one severe blow or multiple minimal strains may affect a tendon at the musculotendinous junction or in the tendon itself or at its point of insertion.[4] Swelling surrounds the injured site with pain, tenderness, crepitus and limitation of motion. Gentle application of Ger-O-Foam with ultrasound therapy of 1.5 watts/Cm^2 for 5 minutes in 6 cases of tenosynovitis including 2 cases of sesamoiditis for more than 30 applications resulted in marked reduction of symptoms.

Painful Healed Fractures: Any case of prolonged immobilization of a limb in a cast with resultant muscular weakness due to disuse may be aided by properly applied massage. This will induce better nutrition and may prevent muscular atrophy. Painful bone lesions are favorably influenced by Ger-O-Foam massage by the resorption of edema, the softening of induration and loosening of adhesions. Four cases of postfracture in bones of the foot, two phalangeal bones, and two metatarsal bones were prescribed home care with this treatment.

Fibromyositis: This appears to be an involvement of white fibrous connective tissue by a hypothetical toxin.[5] One case was treated by home care with Ger-O-Foam massage. Symptoms subsided within 1 week.

Calcaneal spurs: Acute pain and inflammation of these recalcitrant conditions were relieved by orthopedic treatment and by the repeated application of Ger-O-Foam and ultrasound. Ger-O-Foam, when spread evenly over the integument, may act as its own contact media or it may be combined with baby lotion or mineral oil for more concentrated transfer of the ultrasound rays. Either way the foam gives the patient a sensation of penetration. Four cases of this foot condition were treated in this manner with marked palliation in each case.

Strained plantar fascia: Various traumas to the plantar surfaces of the feet result in metatarsalgia and/or plantalgia. The efficacy of Ger-O-Foam massage in home care for tired, aching, fatigue-ridden feet revealed itself in more than a dozen cases. Alleviation of symptoms was comparable to a hot foot soak, but with less time and effort involved. Some women told me they carried the aerosol can with them in their purse and massaged their feet in a department store rest room when they were part way through their shopping day.

Morton's neuralgia: Two cases of this condition were tested with Ger-O-Foam massage. One case did not respond to any type of therapy and finally had to be submitted for surgery. The other condition had some respite from symptoms of a nonpermanent nature. Orthopedic treatment finally resolved this case. Since the superficial branch of the lateral plantar nerve[6] that is involved in this condition does not lie close to the surface, the medication could not penetrate to the pathologic site. The neuralgia did respond better when the product was used in conjunction with ultrasound.

Ankle sprain: Three cases of ankle sprain responded well to more than 20 applications of Ger-O-Foam with ultrasound between strappings. Also for two other cases that complained of discomfort, especially when the weather changed, owing to old healed ankle sprains, massage with the product at home proved comforting.

Hallux valgus and hallux limitus: These chronic conditions showed themselves to be more amenable to stretching exercise after the application of heat and mild massage

with Ger-O-Foam. Six cases consisting of 36 applications of the product were treated. All responded positively to the massage if not to the orthopedic therapy.

Conclusion

An advantage to having the topical analgesic in an aerosol can is that the molecular particles of methylsalicylate are broken up into tiny individual globular masses with more penetrating power. Massage alone and especially the rotating massaging motion of the ultrasonic head forces the fat-soluble amine containing benzocaine deep into underlying structures. The sedative effect reduces pain and allows motion and exercise otherwise impossible to administer. In no instance in this study was a dermatitis or other side reaction noted. The medication should not be used in those conditions where ordinary massage would be contraindicated.

The results here reported warrant further control and placebo testing to determine how much of the effectiveness of the treatments that have been described are attributable to Ger-O-Foam.

Summary

Forty-eight cases of foot pathology were treated with a topical analgesic agent. All cases were of a musculoskeletal nature. In all but one case (Morton's toe) there was amelioration of pain to some degree. This indicates that the above described surface analgesic acted as an aid in the therapeutic application of massage, ultrasound and other physical therapy modalities.

1845 Summer Street

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"The pediatrician and the general practitioner have a unique opportunity to pick up individual actions and behavior patterns that may presage more overt antisocial acts if left unmodified."

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Revivification and Resuscitation Therapy in Cardiac Arrest

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SOME day, while you watch, you may be confronted with the acute attack and sudden death of a relative, a friend, or a patient presenting symptoms of asphyxia and cardiac arrest.

The surprise will shock the usual bystander into paralytic inactivity. However, there is no time to wait for an ambulance or a personal physician. The podiatrist must bridge the gap between life and death for the victim.

Reversal of death and resuscitation is possible if the following treatment is undertaken before 4 minutes of cerebral anoxia have passed. After 5 minutes, the brain will be irreversibly damaged, thus, the necessity for prompt action by you.

Whether the cause of acute cardiac standstill be from myocardial infarction, reaction to anesthesia, electric shock, choking and strangling, drowning, suffocation, poisoning from gas, carbon monoxide, or drugs, the latest emergency therapeutic action is as follows:

1. Diagnose asphyxia and cardiac arrest.
2. Institute mouth to mouth artificial respiration.
3. Institute concomitant closed chest massage.
4. Carry out further indicated First Aid measures.

Diagnose Asphyxia and Cardiac Arrest

Remember that this treatment must be instituted within 4 minutes. Do not waste time on lengthy diagnosis as the patient may have lost 1-3 minutes already. Quickly, check for following signs and symptoms: no breathing, no heart beat, no pulse, dilated pupils.

Institute Mouth to Mouth Artificial Respiration

A. If you are alone with patient:
   1. Place in supine position on firm surface.
   2. Hyperextend the head and clear the airway.
   3. Pull jaw forward and hold open his mouth with one hand.
   4. Pinch the nostrils with other hand.
   5. Blow and inflate his lungs 3 or 4 times.
   6. Proceed with cardiac external manipulation.
   7. Re-inflate lungs every 30 seconds thereafter.

B. If you are not alone with the patient:
   1. Place patient in supine position on firm surface.
   2. Hyperextend the head and clear the airway.
   3. Pull jaw forward and hold open patient's mouth with one hand.
   4. Pinch his nostrils with the other hand.
   5. Blow and inflate his lungs 3 or 4 times.
   6. Proceed with external cardiac manipulation.
   7. Assign and teach bystander to give continuous mouth to mouth artificial respiration while you carry out the cardiac massage. (If bystander already knows how to give mouth to mouth ventilation, then you both work simultaneously.)

The ancient technique of mouth to mouth artificial respiration is utilized in conjunction with the closed chest cardiac massage because it is the most efficient and most practical method for this situation. The mouth to mouth procedure requires no equipment, and has the advantage of inflating the victim's lungs immediately. It is currently being taught by accredited hospitals and by American Red Cross instructors. The method is clearly demonstrated in the latest Red Cross supplement on artificial respiration.

Other special points to remember in mouth to mouth resuscitation are:

1. Clear the mouth of foreign matter, loosen the tie, and clear the airway.
2. Open your mouth wide and seal the victim's mouth.
3. In adults, blow forcefully into mouth about 12-16 times per minute for continuous Artificial Respiration.
4. In child, blow gently (enough to blow out a candle) about 20-30 times per minute for continuous artificial respiration. (In children and infants, operator may place his mouth over both child's mouth and nose.)
5. After blowing air into lungs, remove your mouth from victim, tilt your head, and listen for patient's passive expiration of air. Continue this cycle.
6. Pressure on the epigastrium to facilitate the passive expiration of air may be needed occasionally. Patient's nasal airway may be sealed also by leaning cheek against his nostril. This will free one hand.
7. Obtain a rhythm and continue until relieved by a hospital team.
8. If mouth to mouth is objectionable because of the personal contact, the following aids may be employed:
   a. A handkerchief or a gauze square may be placed over the patient's mouth.
   b. A Resuscitube Airway® may be inserted. This eliminates direct oral contact. I strongly suggest that this Resusitube be obtained for your office, home, or car.

Institute Closed Chest Cardiac Massage:

A. Patient Supine: The patient is already in a supine position on a firm surface such as the floor, the ground or on a sturdy table.

B. Artificial Respiration Starter: The head is hyperextended, and the lungs have been ventilated 3 or 4 times.

C. Cardiac Compression: The heel of the right hand is placed on the lower third of the patient's sternum. The heel of the left hand is placed on top of the right hand to augment the downward force (may use opposite hands, if so desired). The fingers are not used. The pressure is not exerted on the ribs. The pressure is applied vertically until the sternum is forced downward toward the vertebral column about 1½ to 2 inches. The thoracic cage on an unconscious patient is flexible, and the downward pressure compresses the heart and squeezes out the blood into the arteries. The heart will remain in the proper position for this manipulation as posterior displacement is prevented by the vertebral column, and anteriorly is prevented by the sternum, and laterally is inhibited by the Pericardium.

D. Cardiac Relaxation: Next, the manipulator relaxes and lifts his hands together to permit full expansion of the chest. The relaxation of this pressure permits the heart to fill with venous blood on the right side, and oxygenated blood on the left side.

E. Cycle: The cardiac massage cycle is repeated about once per second or about 60-80 times per minute.

F. Vital Signs: Watch for vital signs in patient.

1. Carotid or femoral pulses.
2. Constriction of pupils.
3. Spontaneous gasping respirations.

G. Continuous Cardiac Massage and Artificial Respiration.

1. Usually the return of spontaneous cardiac activity occurs in 5 to 10 minutes. However, it has proceeded as long as 75 minutes before successful revivification.
2. Treatment should be uninterrupted even while patient is being transferred to a hospital.
3. Treatment is to be continued until the pulses are strong and blood pressure is normal.

H. Other Special Points to Remember:

1. In children up to 10 years of age, the pressure of the heel of one hand

® Johnson and Johnson, New Brunswick, N. J., has devised a plastic-like tubing with mouth flange which can be inserted over the tongue and into the air passageway.

will suffice. NOTE: Be careful, excessive pressure may damage the liver in a child.

2. In infants, the pressure of 2 fingers (not the thumb), at the rate of 2 compressions per second (120 per minute) will suffice.

3. The rhythmic sternum compression and relaxation also assists artificial respiration by decreasing and increasing the chest cavity. However, it is inadequate by itself for oxygenation and must be supplemented by simultaneous mouth to mouth ventilation for maximum efficiency. As stated previously, if concomitant mechanical breathing is unavailable due to the lack of a second person, then lung action must be augmented by interrupting the cardiac massage every ½ minute, or less, in order to inflate the lobes a few times.

I. Further Discussion:

Three Johns Hopkins Hospital research men have developed this technique of external cardiac massage. It is very effective. In more than 100 cardiac arrests patients, over 62% were restored to pre-arrest status.

These men have shown that if external cardiac massage, combined with mouth to mouth artificial respiration, is instituted within 4 minutes, the circulation will be sustained adequately and the central nervous system will not be without oxygen long enough to allow damage.

The external cardiac massage will probably replace the "open chest" method as it eliminates the problems of trauma, blood loss, infection and postoperative complications.

Additional treatment for cardiac infections, cardiac defibrillation, an endotracheal tube, etc., are left to the hospital team.

Carry Out Further Indicated First Aid Measures

As soon as possible after concomitant cardiac massage and ventilation have been instituted, the manipulator directs:

A. A bystander to call the hospital or the police for an ambulance, and instruct the nearest hospital that a cardiac arrest patient is on the way. Be sure that the bystander knows the exact location of the victim.

B. Another bystander to act as his artificial respiration operator, if needed.

C. Someone to obtain blankets and to deftly place them beneath and around the victim without interfering with the treatment.

D. Someone to divert traffic or keep onlookers out of your way.

E. Someone to watch cars for M.D. or station wagon for possible transportation to nearest hospital.

Summary

In cardiac arrest, prevention of death is possible if you institute closed chest cardiac massage concomitant with mouth to mouth artificial respiration before 4 minutes of cerebral anoxia have passed. The necessary procedures have been outlined and described.

26 Lincoln Terrace

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Clinically Speaking

A place for the more informal presentation of reminders, suggestions, notes, observations and technics of value in office practice. Your contributions of short manuscripts or illustrative case histories will determine this section's usefulness.

A Severe Chronic Ischemic Patient—A Case Report

Michael Romano, D.S.C.
Barrington, R. I.

A MALE Caucasian, mesomorphic, age 53, a rubber worker, presented himself with the complaint of painful episodes of the right foot and leg.

History and Examination

At the first office visit, the patient complained of a burning pain present at the plantar surface of the right foot, with marginal complaint associated medially and laterally in a dorsal projection. The burning was severe when the patient lay in a recumbent position or upon prolonged sitting with the leg in a position of dependency. The pain became so intense as to awaken the patient three or four times during the night. Upon prolonged walking, an intermittent claudication-like pain appeared in the lower leg and foot. The patient was unable to pursue his normal work, and was so incapacitated as to be reduced to an extremely quiescent existence. A psychological depression was becoming entrenched, and the patient's despairing and morose attitude was obvious.

Approximately 6 months prior to his appearance in the office the patient experienced an episode of arterial occlusion of the right leg and foot. Pulses were diminished, the foot and leg cold and cyanotic. All symptoms very strongly suggested a definite occlusive process. Immediate thrombectomy was performed high in the iliac artery and a thrombus was removed.

The patient did not respond as expected, and excruciating pain continued to such an extent that a unilateral sympathectomy was performed to attempt to offset the crucial episodes. The patient still did not respond, and was pain-free only when confined to complete bed rest, and at that, the pains of ischemia were present to such a degree that the use of analgesics and antispasmotics was necessary. The patient was discharged from the hospital, and the surgeon remarked that since the residual problem was apparently not subsiding, and inasmuch as no danger was present from clots, the condition would remain at a status quo. A return to normal life and occupation was not anticipated.

In our history we learned that he had recurrent migraine cephalgia and fixed hypertension was noted. Otherwise there were no abnormal findings discovered by us or reported to us by his family physician.

On examination, the left foot was apparently normal in dimensions as well as to muscle tonus, morphology, joint movement, etc. The afflicted right foot displayed a marked atrophy of all visible tissues including the musculature. Motion was restricted predominantly in eversion and dorsiflexion. The patient assumed an antalgic limp fixed in inversion and plantar-flexion. Tenderness was noted at the cuboidal-metatarsal and talonavicular joints. Edema was not present.

In the vascular examination of the right foot we barely elicited a pulse in posterior tibial artery and none in the dorsalis pedis. The foot was markedly cold both objectively and subjectively, and the skin was definitely cyanotic on elevation and assumed a sickly rubor on dependency. Oscillometric readings confirmed our impression of decreased arterial circulation. Numerous telangiectasies were noted. The left foot was essentially normal. All reflexes, tendon and superficial, were essentially normal.

The skin displayed the marked atrophy usually seen in these problems. The color

reaction was abnormal as described, especially was the dependency test marked. The area was dry and cold and the stretched appearance of the skin evidenced the underlying pathology. The skin of the left foot was normal. An incidental onychophosis of the right hallux was noted.

Diagnostic Impression

In spite of the previous proven organic closure of the artery, i.e., by actual removal of a thrombus, we felt that a definite vasospastic element was present. The condition is unilateral; the patient was a heavy smoker up to the time immediately prior to his hospitalization. It was also possible that this was a variation of thromboangiitis obliterans. The fact that a high sympathectomy had been performed and was apparently ineffective, does not rule out vasospasm, as the ultimate effect of this procedure may be delayed for periods up to 6 months. It was our definite impression that there was arterial spasm with occlusion, and any obstruction was considered to be a segmental fibrosis, or an arteriosclerotic process.

Of interest, it must be noted that at the time the patient reported to us, his problem involved not only intermittent claudication-like pain and nocturnal episodes of ischemic neuritis, but what appeared to be a local arthro-osseous problem. In the course of examination, it was found that the areas of the cuboid and the talus at their anterior articulation were exquisitely tender to touch. These areas were definitely involved in the patient's inability to ambulate, and because of the ischemic situation we postulated an avascular dysplasia-like process.

Treatment Program

In order to permit the patient to obtain a full night's sleep, and to overcome the severe nocturnal episodes, massive doses of vitamin B_{12} were given at the rate of 1000 mcg. intramuscularly bi-weekly, until subsidence of the pain. This occurred after administering a total of 8000 mcg. To overcome the spasms in the foot, and to attempt to promote rapid collateral circulation and/or earlier recanalization (depending on the actual pathology), nerve blocks were given bi-weekly to the sural and the posterior tibial nerves, using on the average, for each nerve, 3 cc. 2% Xylocaine®[1] with 100 mcg. of B_{12}. The time required to obtain relief and increase temperature, but no pulse gradient, was 5 weeks. Shoe therapy, including a Morton's platform, with longitudinal pad and cuboid block, was used to relieve the tender areas of the previously discussed osseous structure.

This, coupled with the medical program, afforded grateful relief.

Present Course

At present, the patient has returned to work, despite the surgeon's and our own initial prognosis (we had only hoped to provide the patient a pain-free quiescent status). A normal working day is now possible with return to 85 to 90 per cent of normal capacity. The only residual complaint is intermittent claudication of the upper calf on prolonged walking.

Discussion

The effect of B_{12} therapy for ischemic problems of sleeping or prolonged sitting positions are known. The beneficial results obtained by repeated nerve block, we feel, are worthy of further investigation. For whether we have produced a relaxation of spastic arteries, recanalization, or increase of collateral circulation, we do know that the foot is now warm and functional, within limits to be sure. However, a patient previously doomed to an existence of very limited activity can now assume a near-normal life.

184 E. County Road

[1] Astra

Curettage and Cautery Of Verrucae

Selwyn P. Schenkman, Pod.D.*
Bronx, N. Y.

MANY techniques for the treatment of verrucae have been presented over the years. These have included cautery, injection therapy, surgical excision and curettage. The following technique is a modification of a curettage procedure previously described by Prazak and Thomas[1], Weinstock[2], Overcast[3], and Lerner[4].

The foot is prepared for surgery, and anesthesia is attained by local conduction or field block. Using a large cutting mastoid curette the verruca is removed in toto by blunt dissection. This is performed by holding the curette at the edge of the lesion and with a firm downward and upward motion the verruca is "scooped out." The curette is then passed around the periphery and base of the now formed crater until all soft spongy verrucous material has been removed. The curette will only remove the spongy pathologic tissue and will pass directly over integument of healthy consistency. Throughout the procedure hemorrhage is controlled by digital pressure. After all the verrucous tissue has been removed a deep cavity with a smooth, tough, glistening white fibrous base should be observed. A curved Mayo scissors is used to cut away the overhanging skin. The base and side of the crater are now cauterized with 75 per cent silver nitrate applicator sticks or by superficial electrocautery with a hyfrecator. The crater is packed with antibiotic ointment, preferably bacitracin which because of its high petrolatum content prevents adhering of the dressing to the wound. A dry sterile dressing is applied. Postoperative pain is minimal and controlled by analgesics. The patient is permitted to be ambulatory. The lesion is redressed at weekly intervals until complete healing takes place, which is approximately 2 to 3 weeks.

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A modification of a previously described technique for the treatment of verrucae has been presented. This procedure affords permanent eradication of the lesion with complete ambulation of the patient, minimal postoperative pain, rapid healing, lack of painful scar formation, a good cosmetic result and can be performed on weight and non-weight bearing surfaces, with little or no loss of time from daily activities. *406 E. 149 St.*

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Freiberg's Infraction: Is It More Common Today?

Harold J. Feder, D.S.C., F.A.C.F.O.
Chicago, Ill.

IN recent months our practice has seen several cases of a condition that was heretofore considered uncommon. I am referring to juvenile Freiberg's infraction (an aseptic-necrosis) of one or more of the metatarsal heads. In 17 years of practice (with an extensive children's clientele) I had treated no more than three or four cases of Freiberg's per year. Now, in a few months, I handle more of this condition than I did previously in a full year. I have selected from my files four cases of what I consider to be typical examples.

Case #1—White, female, age 11, slightly obese, appeared with a limping gait of the left foot, obviously suffering a great amount of discomfort. Examination revealed an area of painful edema with an increased localized temperature of the area overlying the second and third metatarsal heads

on the plantar surface of the left foot. Full, dorsoplantar, weight-bearing X-rays revealed an increased joint space between the second metatarsophalangeal articulation; a localized area of demineralization appeared in the left second metatarsal head. The affected head appeared "squarish" in comparison with the others. Diagnosis: Aseptic-necrosis, left second metatarsal head.

Case #2—White, female, age 14, appeared in my office complaining of pain on weight-bearing for last few days. The area of discomfort was the ball of the left foot. Examination revealed a localized area of tenderness on the plantar flexion of the second toe. An extreme amount of pain was elicited on palpation. Full, dorsoplantar, weight-bearing X-rays revealed a localized area of increased bone density, surrounded by an area of bony demineralization. A similar area of eburnation, surrounded by an area of bony demineralization appeared at the base of the proximal phalanx. There was juxtaposition of heads two and three bilaterally and bipartite tibial sesamoids. Diagnosis: Incipient Freiberg's infraction, left second head.

Case #3—White, female, age 13, presented herself with an acute, severe pain in her right foot. This young lady had to be assisted and supported under the arms by her parents, as weight-bearing could not be tolerated on the affected limb. Examination revealed an area of edema and extreme pain on palpation over the second and third metatarsal heads, dorsally and plantarly. Slightest pressure anywhere on the forefoot was unbearable, bringing tears to the eyes of the patient. The forefoot was hot in comparison to the left foot and there was an elevation in body temperature, 100°. Dorso-plantar, full weight-bearing X-rays revealed a squaring of the third metatarsal head, right foot. An area of increased bone density surrounded by an area of bony demineralization. The second metatarsal head showed bony demineralization with a general broadening of same. Both tibial sesamoids were bipartite. Diagnosis: Freiberg's infraction, third metatarsal head with incipient aseptic-necrosis of the second head, right foot.

Case #4—White, female, age 11, appeared in my office limping and complaining of an extreme pain in the ball of the left foot for a period of a few days. Examination revealed a localized area of increased temperature with much pain on palpation under the second and third metatarsal heads, left foot. Full weight-bearing X-rays showed a metatarsus primus varus with a bilateral juxtaposition of heads two and three, however, the left was much worse. The epiphyseal line in the third left head was substantially widened within the head itself. A localized area of increased bone cortex, surrounded by an area of demineralization, not present in its fellows, was visible. Diagnosis: Incipient Freiberg's infraction, third metatarsal head.

There is no need here to go into the details of the therapeutic handling of this condition. Suffice it to say, they all responded quickly to physiotherapy, accommodative padding and a rigid soled shoe.

The frequency of occurrence of this situation prompted me to inquire of my colleagues who handle a goodly number of children as to their recent experience. Strangely enough, among those who practiced in the lower income bracket neighborhoods, there was no particular increase of this malady; however, those who, like myself, were practicing in upper income bracket areas, had noticed this substantial increase of aseptic-necrosis.

Further discussion revealed that it had become the fashion in our areas for children, particularly girls, to wear soft-soled gym shoes and soft thin-soled "bubbles" the major part of the time. When we were children, only the poorer element were the ones who wore thin-soled, half-tennis shoes for daily wear. Now during the 1960's the reverse is true.

Conclusion

Thin rubber-soled shoes for daily wear may have become a major factor in producing an upsurge of juvenile Freiberg's infraction. These shoes, the concrete side-

walks, the inelastic walking surfaces in modern schools, plus the overweight factor are, in my opinion, the major contributing causes in this upsurge of Freiberg's Infraction.

Summary

A recent upsurge in the incidence of aseptic-necrosis of the metatarsal heads has been noted. Some typical case histories have been cited. The suggestion is made that the present increasing use of these rubber-soled shoes may be the principal contributing factor to the noted increased incidence of aseptic-necrosis.

2349 Devon Ave.

Hypnosis in a Case of Multiple Verruca

Lynn A. Wygant, D.S.C.
New Castle, Pa.

ALTHOUGH the virus etiology of verruca vulgaris, verruca plantaris, and verruca plana juvenilis is well established, the inexplicable fact remains that there is a known psychosomatic relationship in these infections. This is especially well known in the last type of verrucae. This paper presents an interesting case demonstrating this relationship in a patient with plantar verrucae.

The patient was referred to us by a dermatologist for hypnotherapy. The patient had 53 acute verrucae (not mosiac warts) on the plantar surface of both feet that had been present for 2 months.

He was inducted and deep hypnosis resulted. At the same visit he was also regressed; however, no information was gathered which was pertinent to the condition except that he had worked day and night to establish himself in his own business. The result of his efforts was a partial nervous breakdown. After the nervous breakdown, the patient began developing symptoms such as anxiety and nervousness. Reading exciting news, watching TV, and after eating would bring about fatigue, shortness of breath, restlessness and fitful sleeping. His symptoms later became quite severe and practically any event would excite the appearance of severe cramps in the abdomen, nausea, anxiety, followed by severe acute asthma and a great fear of death, sometimes accompanied with syncope. Family and past history were essentially noncontributory.

The palliative treatment was as follows: Very slight excavating was done on the verrucae and felt pads were fitted over some of the verruca (cutting out an aperture to fit some of the verruca). With wakening hypnosis, it was suggested that the patient watch the proceedings. He was advised that very strong medication would be applied to each verruca and when he returned on his next visit the verrucae would all appear white as the medicine would burn and soften the condition. A placebo was actually used, in fact a pantomime of applying medication was performed.

When the patient returned, the growths had a bleached appearance and we were able to cut away a great amount of the verrucous tissue without hemorrhage or pain. In the following treatment, use of medication was not mentioned nor was there any medication used. On each visit the verrucae had greatly diminished, with much comfort to the patient. However, the felt padding was continued.

In 1 month the feet were entirely clear of the lesion.

The suggestions given to him were to relax and rest, to remain composed and to mentally adjust himself to expect only the fruits of average effort, and to enjoy his family and home.

Symptom removal was at no time used. Since the patient was to leave town, the post-hypnotic suggestions given were to write our name daily, think on the abreaction during the visits, and to write or call us.

At this date the patient is considered, in our opinion, entirely free of psychosis and the resulting skin condition. In view of its severity we feel that the results with hypnotherapy were indeed dramatic.

First Federal Plaza Bldg.

Book Review

National Formulary XI

Prepared by the Committee on National Formulary under the supervision of the Council, by authority of the American Pharmaceutical Association. Official from October 1, 1960. Price $9.00.

This edition, N.F.XI, the eleventh since 1888, provides official specifications for many widely used drugs not previously included in either the U.S.P. or the National Formulary. Among the 250 new admissions to N.F. XI are such important items as Aluminum Acetylsalicylate, Chlorotrianisene, Ethinamate, Gramicidin, Oleandomycin Phosphate, Rauwolfia Serpentina, Sodium Cyclamate and Xoxazolamine. In addition, formulas and standards are continued in the new National Formulary for many U.S.P. XV drugs not admitted to U.S.P. XVI.

In the process of revision, many individual specifications for strength, quality and purity of previously official drugs have been completely revised and improved. Nearly every part of the book has undergone revision.

An important change in the new N.F. is the adoption of an enlarged two-column format. This change has made it possible to reduce the number of pages by one third while providing space for nearly 100 more monographs.

The new National Formulary XI represents the culmination of 4 years of planning and work by the members of the Committee on National Formulary, the staff of the American Pharmaceutical Association Laboratory and hundreds of collaborators. The need of the practicing pharmacist, as well as the use of this book as a legal standard, has been constantly in mind in the preparation of this new edition.

Summary: Includes monographs on 250 newly admitted drugs. Provides standards for 815 basic drugs and dosage forms. Includes 82 more monographs than the 1955 edition. Reflects trends in therapeutics. Required by law as part of minimum equipment for pharmacies in most states. Published by the American Pharmaceutical Association as a service to the pharmaceutical and allied health professions and to the public.

Note

Of great importance to Podiatry: Pages 491, 492 and 493 contain our special section, "Chiropody-Podiatry Drugs and Preparations." The writer and the Council on Podiatry Therapeutics and Pharmacy recommend this valuable book to the profession and to every practitioner of podiatry-chiropody. Your Council is also part of the Advisory Board serving as Advisory Committee on Podiatry Preparations.

Harry L. Hoffman, Ph.G., D.S.C.

JOURNAL
OF THE
AMERICAN PODIATRY
ASSOCIATION

The Official Publication of the Podiatry-Chiropody Profession

PUBLISHED UNDER THE DIRECTION OF THE BOARD OF TRUSTEES BY THE
AMERICAN PODIATRY ASSOCIATION
3301 Sixteenth Street, N.W., Washington 10, D. C.
A. RUBIN, D.S.C., Editor

Communications regarding manuscripts, news items, and editorial matters should be addressed to the Editor, those regarding advertising to the National Advertising Representative.

President's Inaugural Address

"To whom much is given, much shall be required."

You have conferred upon me the highest honor within our association. I accept that responsibility with great humility, and a realization of the great task before me. You have assumed an equal responsibility to aid and assist me in every way possible. With your unlimited support I am certain that we can, by working together, accomplish something of good for the podiatry profession.

The American Podiatry Association is your association. The ramifications of the A.P.A. are many. It should be a guiding light to all of us, remembering that it is only an amalgamation of component parts, the state societies and their component divisions.

Podiatrists in many states have heard me proclaim that our profession needs to be united and informed at all times. Working together we will act as a unit and speak with one voice, instead of many. In this way we will offer clarity of aims and objectives, instead of confusion of purpose.

The illustrious men who have preceded me have, each in his own way, performed a magnificent task. Perhaps a number of their objectives were not realized but their accomplishments, nevertheless, have been great. The growth and development of the American Podiatry Association and the profession of podiatry has been phenomenal. Its place in the fraternity of allied medical organizations is becoming secure. Its influence with allied medical groups is gaining strength. Its officers and executive personnel are devoted, capable, and sincere. Its prospects for the future afford opportunities unlimited!

What course are we to chart this coming year? What are the problems facing us? How may we advance toward that perennial goal of improved foot care for an ever-increasing nation? These are questions we seek to answer each year as each succeeding President takes office.

Robert Shor, D.S.C.

Los Angeles, California

Assumes Office of President

AMERICAN PODIATRY ASSOCIATION

(National Association of Chiropodists)

We have been charged with the responsibility of developing a five-year plan. The plan calls for the selection of certain projects for conclusive accomplishment each year. It is recommended that each affiliate state society coordinate their activities in order that we may develop not merely as a unit but also on a collective basis.

The plan calls for a continuation and further development of our "four phases" programming – namely, EDUCATION, PUBLIC EDUCATION AND INFORMATION, ALLIED HEALTH RELATIONS, and HEALTH INSURANCE and INDUSTRIAL HEALTH RELATIONS.

The Council on Education and the Board of Trustees of the A.P.A. have indicated sincere concern that there be implemented careful planning directed toward the expansion of educational facilities in podiatry. The podiatry profession, in recognition of a rapidly increasing population which is becoming more foot health conscious, will require a more adequate supply of well-trained professional people to meet the demand of caring for the nation's foot health.

In August 1960, our House of Delegates authorized the establishment of the Special Commission on the Status of Podiatry Education "to examine with a broad perspective, the profession's educational program and recommend steps necessary to improve this program." This report has been completed. Within education we share a common bond. We have a moral obligation to implement the recommendations of the Special Commission on Podiatry Education. This we will do.

Public Education and Information has a tremendous impact, reflecting everything we say and do. It is through P. E. & I. that the image of podiatry is portrayed to the various publics, informing them of the importance of good foot health to total good health. The professional public relations man can only act as advisor or consultant. The overall responsibility of P. E. & I. remains with the podiatrist and podiatry. There is a great need for further promotional literature and articles. We must expand our library on educational and informative materials. This too will be accomplished.

Allied Health Relations–Liaison and lines of communications have been established with organized medical groups. We shall continue these contacts to enable the American Podiatry Association to establish our areas of agreement and resolve our disagreements. The question is not whether a man limits his practice, but whether he has been properly trained and is otherwise qualified. We must and we will develop a standard professional definition of the practice of podiatry. We must know where we are going.

Health Insurance & Industrial Health Relations–Your A.P.A. will continue its contacts with the Insurance Industry, Industrial Health officials, Federal health agencies, and any other agency where the recognition and inclusion of podiatry is a must and a justified right.

The American Podiatry Association, as a service organization, has a responsibility to serve its component societies, its members. On the other hand, the component societies have an inherent responsibility to better coordinate activities and set up better lines of communications. An informed membership is an active and enthusiastic membership. They have a responsibility to follow through on the programs provided on a national level. Unilateral action by individuals hampers programs. The A.P.A. serves as a clearing house for all activities which have National significance. In this way we can better serve one another, thus developing as a unit.

The programs developed will be in relation to the degree of their importance. All our other activities will continue but will be subordinated to our major needs.

I predict as a result of our realignments, we will find the emergence of a new enthusiasm which will dispel all sense of complacency within our ranks. As our lines of communications develop, they are bound to affect the thinking of our membership, and to affect it for the better.

As a fitting conclusion may I leave you with this thought by Nathan C. Shaeffer from "Leaves of Gold"—

"At the close of life the question will be not how much you got, but how much have you given; not how much you have won, but how much have you done; not how much you have saved, but how much have you sacrificed; how much you have lived and served, not how much were you honored."

ROBERT SHOR, D.S.C.

Preliminary Report
1961 Annual Meeting

The forty-ninth annual meeting of the Association was held at the Americana Hotel in Bal Harbour, Miami Beach, Florida. Preliminary to the meeting, the Board of Trustees met for three days and the Council on Education for two days. The Reference Committees for the House of Delegates met on Wednesday, August 23rd. The House of Delegates met on August 24th, 25th and 27th.

The theme of the scientific meetings was "Communicating in Health Education." This theme was supplemented by breakfast sessions which repeated the great success of these sessions at the 1960 meeting. Subsidiary theme of the meeting was "Aging With A Future—Today."

Robert Shor was honored at the Inaugural Banquet on Monday, August 28th, when he delivered his inaugural address. Outgoing President, Marvin D. Marr, was honored at the President's Reception and Ball on Saturday evening, August 26th.

At the meeting, Robert Shor of Los Angeles, California, was installed as President; Benjamin C. Mullens of Binghamton, New York, was elected President Elect; Joy E. Adams of St. Petersburg, Florida, First Vice President, and Earl G. Kaplan of Detroit, Michigan, Second Vice President. James A. Conforti of Bedford, Ohio, and L. B. Thompson of Kenosha, Wisconsin, were re-elected to three-year terms on the Board of Trustees and Lawrence G. Lefler of Fremont, Nebraska, was elected to fill the two-year balance of the unexpired term created by the election of Earl Kaplan as Second Vice President. Irving Yale of Ansonia, Connecticut, and Edward L. Tarara of Rochester, Minnesota, were re-elected and Theodore B. Eden of Bayshore, Long Island, New York, was elected to three-year terms on the Council on Education. Dr. Donald V. Anderson of Chicago, Illinois, was approved for a three-year appointment to the Council on Education. Leo N. Liss, San Francisco, California, and Jonas C. Morris, Audubon, New Jersey, were re-elected Speaker and Vice Speaker, respectively, of the House of Delegates. Sidney Hirschberg of Forest Hills, Long Island, New York, H. A. McAninch of Spartanburg, South Carolina, and Chester A. Nava of Louisville, Kentucky, were elected for three-year terms to the Board of Trustees of the American Foot Health Foundation. Seymour H. Jacobson of New Haven, Connecticut, was elected for a three-year term to the Board of Trustees of the Fund for Advancement of Podiatry-Chiropody Education.

A major milestone this past year was culminated at the House of Delegates by the presentation of the report of a Special Commission on the Status of Podiatry-Chiropody Education by the Chairman of the Commission, William K. Selden, Executive Secretary of the National Commission on Accreditation. Copies of the report have been mailed to every member of the Association. The excellence of the report inspired the House of Delegates to vote a $10 assessment on each member this year to be used to provide dollar-for-dollar

matching grants to podiatry-chiropody schools for the employment of full-time teaching and research personnel, as the first step in the implementation of the 26 recommendations of the commission's report.

The House of Delegates considered 78 resolutions (29 of these covered financial matters requiring consideration by the Finance and Budget Committee of the House) and a large volume of reports submitted to it. The House of Delegates, recognizing the heavily expanded activities of the Association, and on the recommendation of the Board of Trustees and the Budget and Finance Committee, approved the search for a full-time Executive Director for the Association and a deficit budget approaching $20,000 for the fiscal year 1961-62. It also approved an increase of the A.P.A. annual dues structure to $65 from $40, beginning with June 1, 1962. Ten dollars of this amount is earmarked for the matching grants to the schools mentioned above.

The following 1961 Annual Stickel Awards for Research in Podiatry-Chiropody were made: Gold Medal (1st Place), "Sublesional Administration of Corticosteroids" by Herbert Prentice, New York, New York; Silver Medal (2nd Place), "The Clinical, Anatomical and Mechanical Analysis of the Tibialis Anticus Muscle and Its Tendon," co-authored by P. R. Brachman, L. R. McCain and W. A. Oberheim of Chicago, Illinois, and E. S. Burger of LaGrange, Illinois; Bronze Medal (3rd place) to the following three papers, "New Uses of Chymotrypsin in Podiatry" by Frederic B. Streiker, Broadview, Illinois, "Varicose Venules, A Cosmetic Entity" by J. Stanley Landau of Philadelphia, Pennsylvania, and "Skin pH and Tinea Pedis, A Hypothesis" by Morton H. Walker, Stamford, Connecticut; Honorable Mention, "Podiatry and Peripheral Vascular Diseases" by W. A. Pepin and W. H. Lauritsen of San Diego, California, "Preliminary Results of a Study Conducted to Formulate the Best Treatment Regimen for Onychomycosis" by Walter E. Carpenter, Porterville, California, and "Educational and Rehabilitative Approach to the Podiatrically Handicapped Child" by Kermit Calmenson, Brooklyn, New York.

The following medals were awarded to Scientific Exhibits: 1. Individual—Class A (supported by grants-in-aid); Gold—Herbert Prentice, New York, New York, "Triamcinolone Intralesional in Podiatry"; Sterling—Reginald Farrar and Milton Ashur of Jersey City, New Jersey, Griseofulvin in Tinea Pedis and Onychomycosis"; Bronze—Frederic Streiker, Broadview, Illinois, "New Uses for Chymotrypsin in Podiatry"; Honorable Mention—Seymour Blau, Jersey City, New Jersey, "Conservative Therapy of Vascular Lesions of the Lower Extremity." 2. Public Education and Information; Gold—Greater Philadelphia Chiropody Society, "1961 Fitness Five Hike"; Sterling—American National Red Cross, "American Red Cross First Aid Anniversary, Small Craft and Water Safety"; Bronze—Broward County, Florida, "Second Annual Fitness Five Hike." 3. Institution sponsored (schools, hospitals, specialty groups); Gold—American College of Foot Orthopedists, "Clinical, Anatomical and Mechanical Evaluation of Anterior Tibial Muscle"; Sterling—Ohio College of Chiropody, "Factors of Intractable Plantar Keratosis"; Bronze—Civic Hospital of Detroit, "Surgical Resident Training Program"; Honorable Mention—American College of Foot Surgeons, "Surgical Procedures of the American College of Foot Surgeons." 4. Junior and Senior High School Students for Outstanding Health of Science Fair Exhibits on Foot Health; Gold—Junior Division, Miss Carole Adams, St. Petersburg, Florida, for her exhibit, Jr. High School Health Fair, "Systems of the Foot and Leg."

It is estimated that more than 1500 persons attended the sessions, meetings and exhibits. A preliminary count indicates that 500 podiatrists-chiropodists, 100 members of related professions and associations, and 140 technical exhibitors and advertising representatives were registered. There were 72 exhibits displayed—46 in the Technical Exhibits Section and 26 Scientific Exhibits in the Hall of Science. Over 500 wives, husbands, children and friends of members were present. The Third Annual Association Golf Tournament attracted a good many contestants in both the men's and ladies' divisions.

Pharmaceutical Preparations for the Profession

Harry L. Hoffman, Ph.G., D.S.C.
Chairman, Council on Podiatry, Therapeutics and Pharmacy

A column devoted to preparations, new and old, with emphasis on their value and uses in everyday podiatry practice. This is a regular monthly column prepared from information furnished by the pharmaceutical house. We invite questions, which we shall endeavor to answer, or obtain the answer.

Chymoral Tablets

Description: Oral systemic Anti-inflammatory enzyme. Chymoral is a tablet specifically formulated for oral administration and intestinal absorption. Each tablet provides enzymatic activity equivalent to 50,000 Armour Units, supplied by a purified concentrate which has a specific trypsin and chymotrypsin activity in a ratio of approximately six to one.

Action and Uses: Chymoral affords convenient, oral administration of systemic anti-inflammatory therapy. It is effective as the anti-inflammatory agent or as adjunctive therapy in all conditions where inflammation, swelling and pain prolong the clinical course. Chymoral speeds reduction and absorption of hematoma and edema in trauma; is useful as an adjunct to the conventional measures in the inflammatory dermatoses; stimulates healing processes, either alone or in conjunction with other agents in acute and chronic pelvic inflammatory disease, mastitis, thrombophlebitis, phlebitis, episiotomies, postpartum breast engorgement; aids in liquefying tenacious mucus secretions in asthma, bronchitis, rhinitis, sinusitis; prevents or reduces inflammation and swelling in surgical conditions, as: biopsies, cellulitis, mastectomy, plastic surgery, hemorrhoidectomy; promotes faster healing and reduces pain in epididymitis, orchitis, prostatitis; beneficial as adjunctive therapy in peptic ulcer and ulcerative colitis.

Dosage and Administration: Recommended initial dosage is 2 Chymoral tablets q.i.d. The tablets may be used alone or as a supplement to parenteral Chymar depending upon the severity and duration of the inflammatory condition. Chymoral is compatible with other therapeutic agents as: chemotherapeutics, antibiotics and endocrines. The use of steroids does not interfere with or destroy the enzyme. There are no known incompatibilities. The incidence of side effects is insignificant, and usually of a mild type.

Supply: In bottles of 48 tablets. By Armour Pharmaceutical Company, Kankakee, Ill.

Keralac

Description: Keralac is a solution of chloranil (fungicide) in nail lacquer (0.5% by weight). The lacquer spreads on easily and serves to hold the fungicide on to the nail so that close and intimate contact is assured.

Directions: Remove infected portion of the nail and debride nail bed. Apply Keralac 2 or 3 times a week. Before each application remove the old lacquer with nail polish remover. File or sand the nail down as much as possible. The use of a nail brush is helpful and advisable.

Supply: ¼ oz. bottles complete with brush applicator. By Salem Pharmaceuticals, Naugatuck, Conn.

The following summarizes the history and background of Keralac, the first nail lacquer specifically formulated for distal fungus of the nails:

Chloranil which is the active ingredient in Keralac is Spergon, a powerful fungicide. Spergon is a powerful fungicide use-

ful for protecting growing crops against attack by soil fungi. This item is manufactured by the U.S. Rubber Company. Spergon was found remarkably effective against a variety of dermatological fungus infections.

The best way to formulate Spergon for fungus of the nail was found to incorporate it into nail lacquer, a vehicle that would hold the fungicide close and intimately in contact with the nail. The result is Keralac which is a solution of Spergon (chloranil) in nail lacquer. The concentration of the chloranil in Keralac is 0.5% but when the lacquer dries the concentration rises to around 2.5%. Keralac functions by presenting a fungicidal surface to the freshly filed nail. It is particularly indicated in a distal fungus infection. It is not indicated where the fungus has penetrated under the proximal border and can no longer be reached by topical therapy.

In your office remove as much infected nail as possible, debride the nail bed and apply Keralac. Instruct patient to, twice weekly:

1. Remove old Keralac by nail polish remover (so that the file or emery board will not gum up).
2. File or sand the nail down as much as possible.
3. Paint the freshly filed nail with Keralac.

It should be emphasized that the patient should sand or file the nails down twice weekly (at home). Unless this is done, the results will be disappointing. Patient should be advised that the condition is stubborn and requires time. (Spergon is the trade-mark of the U.S. Rubber Company.)

ZeaSorb

Description: ZeaSorb utilizes as its active ingredient Zea Mays, which has unusual absorptive qualities without caking. It absorbs up to 5 times its own weight of moisture. Zea Mays is a pure, starch-free cellulose. Unlike starch, it will not support pathogenic molds or bacteria. The maker of this powder asserts that ZeaSorb is the first super-absorbent body and foot powder.

Zea Zeta Mays Pith, the chief ingredient, is responsible for the highly absorptive qualities of this powder, also Para-Chloro-Meta-Xylenol 0.5%, an effective antibacterial and antifungal agent; also Aluminum Dihydroxy Allantoinate 2% is an effective but mild astringent, which also provides healing, anti-inflammatory action. Also included is 5% Hexachlorophene, an antibacterial agent. It is nicely scented, nontoxic and nonirritating with no side effects.

Indications: Itching and chafing, useful wherever an absorbent body or foot powder is useful, excellent in Hyperhidrosis, protects and soothes, deodorizes and promotes healing. Also indicated in the relief of athlete's foot, excessive perspiration of the axillae, perineal region and feet. Very useful as a drying agent in certain dermatoses and physical therapy procedures.

Administration: ZeaSorb is dusted freely wherever an absorbent, antifriction, deodorant powder is indicated. It is useful in dusting in shoes and between the toes in athlete's foot. Excellent in dusting under orthopedic supports, colostomy belts, surgical stockings, and on sanitary napkins.

Supply: Available in 2 oz. sifter-top cans. By Stiefel Laboratories, Inc., Oak Hill, N. Y.

Adaptic

Description: A non-adhering packing substance useful in packing or treating draining ulcers or any abscess cavity. It has many uses in dressing wounds of many types, but in podiatry the aforementioned uses seem feasible.

Advantages: Drainage passes into packing strip and does not coagulate. Conforms to body contours, promotes healing, prevents maceration. Provides uniform packing pressure.

Supply: ½" x 4 yds., 1" x 4 yds. in sterile sealed jars. By Johnson and Johnson, New Brunswick, N. J.

Digests From The Literature

Anyone wishing to read the complete article, if not available in your local library, may borrow it through interlibrary loan. A microfilm may be borrowed from the National Medical Library, Washington 25, D. C., or a photo-duplication may be obtained from that library.

Anesthesia and Analgesia

Local Analgesic Drugs, Bryce-Smith, R. British Med. J. 1: 1039-41, 1960.

The properties of an ideal analgesic drug are: provision of a rapid onset and an adequate duration of anesthesia; a low systemic toxicity, so that an adequate volume can be injected without exceeding the maximal safe dose; non-irritating to surrounding structures and without damage to nervous tissues. It should also be soluble in water and stable in solution during storage and sterilization. Toxic symptoms can arise in the central nervous and cardiovascular systems if the rate of administration or absorption of the agent is more rapid than the rate of elimination. The chance of overdosage is increased in patients having serious liver damage. Safety of dosage depends upon the physical condition and age of the patient and also on the site of injection and the particular drug used. Convulsions can be controlled by a minimal dose of barbiturate together with artificial respiration if needed, and restoration of the blood pressure. None of the present agents are ideal.

Besides the widely used drugs, procaine, cocaine, amethocaine, cinchophan, a number of other drugs have been prepared. *Lignocaine,* more powerful but slightly more toxic than procaine, is stable in solution and withstands long storage and autoclaving. It has a short latent period, a tendency to spread, and a pH of 6.4—approximately that of the tissues—and causes neither vasodilation nor vasoconstriction. With no adrenaline added, it produces analgesia enduring for 1½ hours. *Carbocaine,* with similar properties, is effective for more than 2 hours without use of a vasoconstrictor, and produces no side effects. *2-Chloroprocaine* produces rapid onset of analgesia, has a high therapeutic index, and low toxicity. Without addition of adrenalin, duration is only 20 to 25 minutes; pH is 4.9.

Hexylxaine is moderately stable and withstands autoclaving; toxicity is low, and duration of analgesia is about 2 hours. Its use in injections is limited; its pH is low, causing soreness and irritation. *Ravocaine* as a topical agent is preferred to cocaine. Its toxicity is similar to that of amethocaine. It is used in a concentration of 0.1 per cent for infiltration and 0.5 per cent for nerve block. *Piperocaine,* slightly more toxic than procaine, when used in 1.5 solution for caudal and extradural injections produces rapid analgesia. Duration of effect is approximately 45 minutes.

Most long acting anesthetic agents produce some undesirable side effects. "Depot" solutions in wax bases, mucates and ammonium compounds have not proved successful. *Alcohols and phenol* are not analgesics, but cause a long enduring analgesia through nerve block (as in cases of carcinoma). Injection into peripheral nerves produces an effective block, but is followed by alcoholic neuritis which may last for 5 to 6 weeks. Less disturbance is caused by 6 per cent phenol. Vasoconstricting drugs have two functions: prolonging the action of analgesic drugs, and reducing the rate of absorption and thereby the risk of toxic reactions. *Adrenaline* is widely used despite its frequent side effects; these usually result from overdosage or inadvertent intravenous injection. The maximal dosage is 0.5 mg. A concentration of 1:200,000 solution is adequate for most purposes. Hylauronidase, a mucolytic enzyme when used with local analgesic solutions provides rapid pen-

etration of nerve fibers and provides an extensive field of analgesia, but duration is shortened and toxicity increased.

With knowledge of the limitations of the various drugs, choice of a drug will probably depend upon expense, convenience, and familiarity. Effectiveness of analgesia and fewer undesirable side effects will follow recognition of their properties and limitations.

Arthritis and Rheumatic Diseases

Gout, the Rediscovered Disease, Lockie, L. M. Geriatrics 15: 497-502, 1960.

Gout is one type of arthritis that can be held in abeyance completely, if correct diagnosis is made and proper therapy established early. About 1 per cent of the total population, and approximately 5 per cent of all arthritic patients, have this disease—mostly men. Its familial incidence ranges from 50 to 87 per cent. The great toe is usually involved, but the instep, ankle, and heel cord are frequently attacked, and occasionally the knee and hand. The clinical picture is sudden onset of an acute monoarticular attack, with fever, pain and tenderness in the swollen joint. The attack regresses after 4 to 14 days, followed by complete recovery. The attack may be precipitated by physical, emotional or surgical trauma. Tophaceous urate deposits develop after repeated attacks, usually not painful, but may grow so large as to interfere with normal functioning of the joint. When clinical history and physical examination cause suspicion of gout, an elevated serum uric acid and therapeutic response to full doses of colchicine will confirm the diagnosis.

Various courses of treatment are used: (1) Colchicine taken orally is most widely used, 1 mg. every 2 hours until nausea or loose bowel movements occur; then the drug is stopped. Usually 8 to 12 doses are required. The drug may be given intravenously, 1.5 to 2 mg., then repeated in 6 hours, without causing undesirable side effects. If tissues are entered, it is very painful. (2) Phenylbutazone, 200 mg. every 2 hours given for three or four doses, and repeated next day if required, may bring spectacular response. Colchicine, one 0.5 mg. tablet should be given with each dose. The combined action is superior to either drug alone. (3) Triamcinolone (Aristocort®; Kenacort®) given in doses of 8 mg. every 2 hours for four doses and repeated next day, with or without colchicine, is highly effective. (4) Corticotropin (ACTH) in one dose of 100 units given intramuscularly or intravenously in aqueous preparation of 20 units over a 6-hour period brings effective relief. Either procedure may be repeated once daily for several days. (5) Demerol (not codeine or morphine) may be used to control severe pain at onset. (6) The diet during the acute attack should be high in carbohydrates, low in fats, with liberal amounts of fluids, and omission of meat, fish, fowl, and alcohol.

The program recommended after acute symptoms have subsided consists of (1) colchicine 0.5 mg. given orally twice daily for an indefinite period if the patient has more than one attack a year, in order to abort mild attacks. Dosage is raised to full therapeutic level if acute exacerbation occurs. (2) Probenecid (Benemid®) is administered indefinitely if the patient has (a) urate tophi under the skin, or are observed radiologically, (b) more than two attacks a year, or (3) if the serum uric acid is higher than 7.5 mg. per 100 cc. In 90 per cent of patients 0.5 gm. given in the morning and at night is adequate; the remaining 10 per cent may need 0.25 to 1 gm. twice daily. The serum uric acid level should be maintained at approximately 5.5 mg. per 100 cc. Salicylates should not be given with this drug. (3) Zoxazolamine (Flexin®) is a powerful uricosuric drug used in the 10 per cent of patients in whom probenecid does not lower the serum uric acid level. (4) A diet is prescribed, high in carbohydrates, low fat, low purine, adequate protein—regulated to maintain ideal weight.

(5) Alcohol is allowed except beer, wine, ale, vermouth and champagne. (6) Exercise is moderate according to the patient's condition. (7) Large tophi are thoroughly removed. Gouty patients before undergoing any surgery should be given 0.5 mg. colchicine two to three times daily for three days, before operation and for one week afterward.

Use of the Newer Uricosuric Agents in the Management of Gout, Seegmiller, J. E., and Grayzel, A. I. J.A.M.A. 173: 1076-80, 1960.

Sulfinpyrazone (Anturan®) and zoxazolamine (Flexin®) are potent drugs for increasing urate secretion. Not successfully used in acute attacks of gout, they are valuable in prevention and therapy of tophaceous gout, especially in those patients who fail to respond to probenecid, because it fails to adequately lower the serum urate level, or gives rise to adverse reactions. This failure is generally associated with severe impairment of kidney function commonly noted in gout.

Sulfinpyrazone is a chemical relative of phenylbutazone, but with no antirheumatic nor sodium-retaining activity, and has much greater uricosuric activity. Multiple small doses are more effective than a single large dose. Side effects are rare—gastrointestinal intolerance, peptic ulcer, renal colic, and urticaria. Zoxazolamine, a muscle relaxant, increases the urinary excretion of uric acid and lowers serum urate level. When given in a single dose of 250 mg. it may produce a crystalluria.

These two drugs, unless properly given, carry a hazard, precipitating uric acid in the urinary tract, but this can be minimized by a high purine intake, alkalinizing the urine, and by beginning with low doses. Sulfinpyrazone 50 mg. twice a day should be gradually increased to 100 mg. four times a day. Zoxazolamine which is available in 250 mg. tablets is given first in one-quarter tablets twice daily, gradually increased to one-half tablet four times daily for two weeks, according to the patient's need and his serum urate levels. Used together, the two drugs have an additive effect—given in a dose of 200 mg. four times daily, they produce a greater uricosuric effect than other drugs now in use and are of great value in treatment of severe, prolonged tophaceous gout associated with severe renal impairment. The greater potency of these new drugs have an advantage in allowing less rigid dietary restrictions when striving for desirable serum urate levels. Usually a low purine diet is prescribed until the gout is under control, both during acute attacks and during high serum urate levels.

Patients with good renal function and lesser attacks of gout can be adequately treated with probenecid 0.5 to 3 gm. daily. Antagonistic effects are observed in patients receiving salicylates with any of these three drugs. Patients should be warned against taking any drug preparation which contains even very small amounts of aspirin.

Acute attacks of gout are still best managed by use of colchicine. One or two 0.5 or 0.6 mg. colchicine tablets taken when the first symptom appears should abort the attack. If symptoms continue, such tablets should be taken each hour until symptoms subside, or toxicity occurs (nausea, vomiting, diarrhea); this is usually after 6 to 10 mg. have been taken. A regime of daily doses of colchicine may help patients who suffer one or two attacks a year. The frequency and severity of chronic attacks are reduced by taking 0.6 mg. one to four times daily, according to frequency and tolerance. An acute attack may be ended quickly by administering 2 mg. colchicine intravenously in 20 ml. saline solution, with a second dose of 1 to 2 mg. six hours later if the attack continues. Severe attacks of gouty arthritis may be terminated by giving intravenously ACTH, 100 units in long acting repositary gel or zinc form. Early recurrence is prevented by giving colchicine 1 to 2 mg. daily for 1 to 2 weeks.

Dermatology

Erythrasma—Common Bacterial Infection of the Skin, Sarkany, I. and Blank, H. J.A.M.A. 177: 130-32, 1961.

Erythrasma, a skin infection commonly occurring in pubic, axillary and submammary regions and in intergluteal clefts, and regarded as a fungus disease, was found in 9 of 25 normal subjects examined in Miami. The authors further found that the commonest form of the infection occurred as an intertriginous affection of the toe clefts, characterized by fissuring, scaling and slight maceration, between the fourth and fifth toes and between the third and fourth toes, and not due to fungus or monilia. It was noted in 23 per cent of 109 normal subjects examined.

Diagnosis can be made by clinical observance of dry, irregularly shaped, red to brown fine scales, by the presence of coral-red fluorescence seen under Wood's light, and by electron microscopic examinations. On culture, the bacteria develop colonies showing the same coral-red fluorescence under Wood's light. Smears from the colonies showed the presence of gram-positive rods and filaments with granules.

Erythromycin, chlormycetin, or a tetracycline administered systemically to 16 patients with erythrasma on trunk and limbs brought clearance. Erythromycin 250 mg. four times daily for 5 days proved to be the drug of choice. One patient had recurrence in 2 months, another in 6 months; the others remained cured in the 7 months since treatment. Some of these patients had the condition for 5 to 25 years, with no response to therapy. Systemic penicillin and griseofulvin proved valueless. Applied locally, erythromycin and tetracyclines failed to clear the lesions completely. Erythrasma of the toe webs has proved more resistant to treatment than that on the trunk and limbs. Systemically administered erythromycin, while bringing temporary loss of fluorescence and providing symptomatic improvement in the infected toe webs, often fails to afford complete cure.

* * *

An editorial, based on this article (p. 144), comments on the little interest in erythrasma shown until this time, because it has been accepted as a mild fungus disease which responds temporarily to various topical applications. Its chronic course and tendency to relapse after improvement should have led to research into its etiology. Sarkany and his associates have proved its bacterial origin and its response to systemic administration of suitable antibiotics. Their finding that in many cases of scaling and fissuring between the toes the infection is bacterial, not fungal or monilial in origin, may help to explain the gap in understanding cases of "athlete's foot," wherein routine cultures for fungus, monilia, and bacterial have been negative. Because of the incidence of erythrasma in one city alone, the magnitude of the problem cannot be over-emphasized, for example, in the Armed Forces with the type of footwear afforded and hot, humid conditions to be endured. The study should provide impetus to detailed bacterial studies of skin surfaces.

Griseofulvin: Its Potentialities and Its Problems, Carney, R. G., and Ziebell, W. C. Iowa St. Med. J. 50: 199-202, 1960.

Griseofulvin therapy, of no value in nonfungal diseases, is effective in dermatomycoses when given orally, but it presents problems in diagnosis, duration of treatment, and possible relapse, reinfection, and side reactions. The drug is expensive and treatment long, and should not be given unless a positive diagnosis is made.

Organization News

Secretaries of local, state, regional, affiliated, subsidiary and other related organizations are invited to submit copy for these columns.

Arkansas

At the recent meeting of the Arkansas Podiatry Association, the following officers were elected: L. B. Shaw of West Memphis, President; L. J. Thuerk of Fort Smith, Vice President; W. C. Gigerich of Hot Springs, Secretary-Treasurer and Delegate to the national meeting, E. N. Barron. Dr. M. F. Cohen was re-elected to serve another 3-year term on the State Board.

Georgia

President William J. Cox of the Georgia Podiatry Association, presented the "Winged Foot" award to Morton Wittenberg of Augusta, Georgia, for his many years of assistance toward the fruition of professional organizational objectives.

The Metropolitan Atlanta Division of the association has become the first such group in the nation to complete the civil defense course in medical self-help training.

Lectures on "Vocational Guidance" and "Modern Foot Health" were delivered to the student body of Oxford Junior College by E. Dalton McGlamry of Atlanta, and to the students of Auburn University and LaGrange College by William J. Meadors of Columbus.

New York

Dr. Lawrence Namm of Brooklyn, New York, was elected President of the Podiatry Society of the State of New York at the annual meeting of the House of Delegates held at the Hotel Sagamore, Lake George.

Other officers elected were: President-Elect, Lester Bluhm and Vice Presidents, Ernest M. Weiner and David M. Simon.

Chosen as New York State's Podiatrist of the Year, by virtue of his outstanding contributions to the foot health of the public, was Murray Goldstein of Queens.

The following members of the Podiatry

"LIFE'S FOUNDATION — YOUR BABY'S FEET" is an outstanding and comprehensive booklet on the growth and care of children's feet. Written for the layman, it is concise, cleverly illustrated and will prove valuable especially to the parents of young children. Many Podiatrists-Chiropodists have received a copy of this booklet and have ordered them in quantity. For those of you who have not ordered and for those who wish to reorder, please clip the order blank below and mail with your check for your supply.

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THE PHYSICIAN AND THE CANCER PATIENT

The American Cancer Society is concerned with the *total* cancer problem. A crucial part of this problem relates to the cancer patient and his family. To help the medical profession explore ways and means of meeting the patient's special needs, the scientific session of the Society's next Annual Meeting at the Hotel Biltmore in New York City, October 23-24, 1961, will be devoted to "The Physician and the Total Care of the Cancer Patient." Various specialists will examine the psychological and physical problems facing the cancer patient and his family. Consideration will be given to such topics as decisions in the early care of the cancer patient, counselling the cancer patient, what the patient should be told, care of the advanced cancer patient, society's role in service to the cancer patient.

Through such meetings, the American Cancer Society serves the medical profession by providing a forum for an exchange of information and experience concerning the cancer patient.

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Society were elected as Delegates to the Annual American Podiatry Association Meeting in Miami: Milton Werbel, Lawrence Namm, Lester Bluhm, Ernest M. Weiner, John E. Green, Theodore B. Eden, Arnold Pinsker, Frank Greenberg, Murray Goldstein, Arthur Wolstein and Sidney Druskin.

An outstanding decision of the New York House of Delegates was the approval of a special educational assessment of $25 per member for the purpose of supporting podiatry education in the state.

Appointments

Dr. Paul W. Smith of Salt Lake City, Utah, was recently commissioned Captain in the Medical Service Corps of the Army Reserve, being attached to a thousand bed hospital. Dr. Smith, so far, is the only podiatrist in this group.

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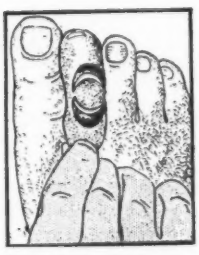

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Elected to National Baby Care Council

Election of Benjamin C. Mullens, Vice President of the American Podiatry Association, to the Board of Directors of the National Baby Care Council, was announced by Dr. Ernest G. Osborne, the Council's National Chairman. Dr. Mullens will guide the organization's concern with the foot health needs of the nation's youth and the prevention of these problems through proper foot care in childhood.

The National Baby Care Council is a non-profit public service organization formed to promote the health, education and welfare of the nation's babies and to concentrate public attention on the baby, its prenatal and postnatal care and needs. The Council is composed of authorities in the various professions in the health field.

Women's Auxiliary Message

This will be my last Auxiliary Message to you, for by the time you receive this copy of the Journal, the Women's Auxiliary will have elected a new group of officers.

We all look forward to a new year, knowing that the coming year will bring further advancement for our profession.

It has been an honor and a privilege to serve as the Auxiliary President these past two years and to have worked with Dr. Marr and with Drs. Rubin and Nyman.

Mrs. Cleotha Parham, President

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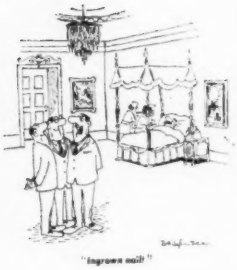

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SURGICAL KNIVES BY Rudolph Beaver

WALTHAM 54, MASSACHUSETTS

Mood Elevators

Contributions to this column are more than welcome. In fact it depends upon them. A.O.P.

She was something of a social climber and was always nagging her husband to move into a more expensive apartment. One day he opened a letter from the landlord, read it, then said, "Good news, darling, now you can live in a more expensive apartment without having to move. The landlord raised our rent."

United States has an atomic submarine which surfaces only once in four years—just in time for the crew to reenlist.

A young mother, worn out after a noisy afternoon, pointed to the five children in front of the TV set. "All's Western on the quiet front," she said.

Middle age is when our tripping becomes less light and more fantastic.

DR. POD

"Funny thing about that guy," said Bill, nodding at a passer-by. "He always wins at poker and gin but he always loses on the horses."

"Maybe," suggested Bill's friend, "it's because they won't let him shuffle the horses."

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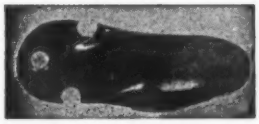

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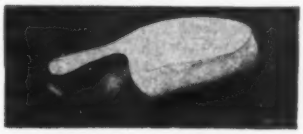

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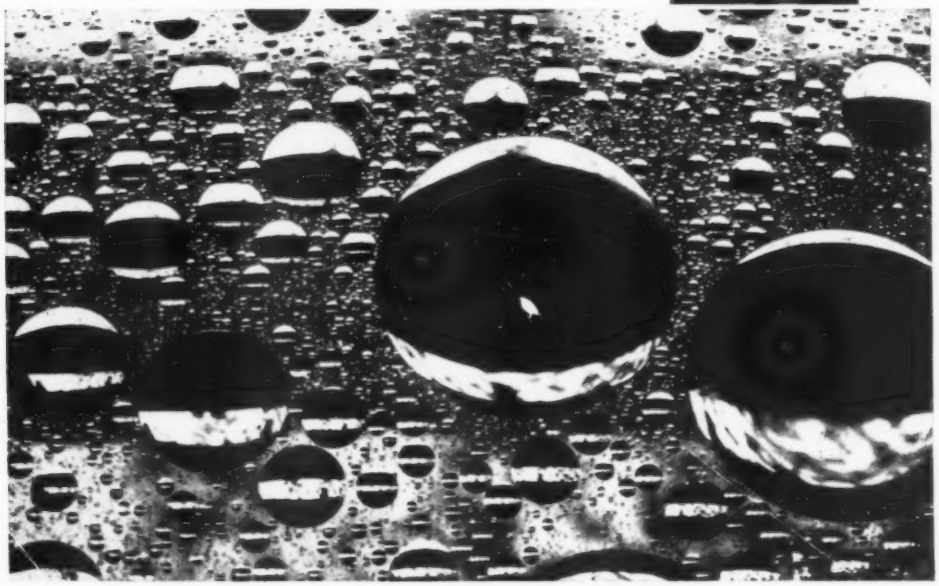

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